



**A Phenomenological Study of Non-Muslim Nurses'  
Experiences of Caring for Muslim Patients in Saudi Arabia**

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## **Dedication**

The study is dedicated to my late father who encouraged me to enter nursing against cultural norms, and my mother who supported me with her prayers, and to my husband Ahmad who was always there for me and sacrificed much for me to complete my studies.

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## **Research Work through the Study Period (2009-2013)**

### **Conferences:**

Alosaimi, D. (2013) Oral Presentation: A Phenomenological Study of Non-Muslim Nurses Experiences of Caring for Muslim Patients in Saudi Arabia. Euro-American Conference for Academic Disciplines. (International Journal of Arts & Sciences) April 8-11, 2013. Paris, France.

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Alosaimi, D. (2011). Second Academic Forum for Saudi Female Students in the UK & Ireland (University of Warwick). May, 2011. Coventry, United Kingdom

### **Courses:**

Alosaimi, D. (2012). Health, Safety and Environment (Diploma). October – December, 2012. Leicester, United Kingdom

## **Abstract**

This study addressed three research objectives related to non-Muslim nurses' experiences providing health care to Muslim patients in Saudi Arabian hospitals. These objectives included: first, understanding what it is like to care for Muslim patients considering both religion and culture; secondly, exploring what it is like being cared for by non-Muslim nurses. In order to address these objectives, the study has employed a qualitative approach, represented in hermeneutic phenomenology. The target groups in this study were Muslim patients and non-Muslim nurses who were interviewed using interviews and focus group discussions.

The study found that religious, cultural and linguistic factors have a negative effect on non-Muslim nurses' experience of care in Saudi Arabia, which included a personal impact, and a practical impact resulting from working practices. However, the results indicated that nurses had some problems with family members who interfered in decisions related to patients, and that they also encountered disrespect from patients' relatives and friends.

The study results indicated that non-Muslim nurses, to some extent, have an understanding of the different aspects and practices of Islam, such as praying, fasting and spirituality. The study results also revealed a significant relationship between spirituality (Islamic faith) and the provision of health care. Nurses believe that religious and spiritual practices have an effect on care. However, they failed to understand the importance of religion and spirituality to Muslims in general and patients in particular.

The lack of training and orientation concerning specific issues of religion and culture negatively affected not only the communication between nurses and patients, but also the provision of health care. It was envisaged that this study would have a positive impact on the delivery of nursing training and education, because it highlights the need to tailor this to specific contexts. The study distinguishes itself from other studies conducted in the same field by investigating non-Muslim nurses' and Muslim patients' confusion between religion and culture. The study stressed an overlap between religion and culture in Saudi society, which consequently affected nurses' provision of health care. It was essential in this study to investigate the differences between religion and culture, to see if non-Muslim nurses would understand religion and culture are not the same; while in some cases they complement one another, in other cases they contradict. Furthermore, the study addressed the issue of professionalism when caring for Muslim patients' and non-Muslim nurses' point of view.

Although nurses claimed to provide healthcare in professional way, they were not fully aware of Saudi local culture or the impact of religion on patient's daily life

It can be concluded, in general, that non-Muslim nurses are facing challenges to providing healthcare to Saudi Muslim patients, due to a lack of understanding of the importance of cultural values and religious practices, and the lack of training and alignment on such issues.

## **Abbreviations**

HCA	Hospital Corporation of America
IPA	Interpretive Phenomenological Approach
KSA	Kingdom of Saudi Arabia
KFSH&RC	King Faisal Speciality Hospital & Research Centre
MOH	Ministry of Health
MOHE	Ministry of Higher Education
NHS	National Health Service
PBUH	Peace be upon him (with reference to the Prophet Mohammad)
RCN	Royal College of Nursing
UK	United Kingdom
USA	United States of America
WHO	World Health Organisation

## **Glossary of Arabic terms**

Abaya            Black clothing for women that covers the entire body

Alaseyat        those who have empathy

Al awasy        those who have empathy

Akul            Eat

Alhamdulillah Phrase ‘all praise is for Allah’

Bismillah       In the name of Allah

Daqeeqa       wait

Evil Jinn        Demon

Hajj            Pilgrimage to Mecca

Hijab           Headscarf

Halal            Permissible

Imam            Member of the clergy

Inshallah       God willing

Kabah           House of Allah

Mahram        Unmarriageable kin

Marhaba        Welcome

Muttawa        A pious man or religious police

Niqab           Face veil

Salam Alikom Peace be with you

Salat            Prayer

Sawm            Fasting

Shahadha       Declaration of faith



Sunnah	Way of the Prophet Mohammad
Taimum	Dry ablution with sand
Wudhu	Ablution
Zakat	Obligatory charity
Zam Zam	Holy spring water from Mecca

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# CHAPTER ONE: INTRODUCTION

## 1.1 Background to the Study

In today's globalised world, there are increasing interactions between nurses and patients of different cultural and religious backgrounds. Healthcare is characterised by ideas about health and disease and caring for patients that differ between cultures. Therefore, the need for training and education in transcultural care in nursing has become imperative. Although transcultural training is now very much part of the curricula in institutions in Saudi Arabia, experience has shown that provisions to teach culturally sensitive care, and the approach to education, research and practice in this area has been inadequate (Narayanasamy and Andrews, 2000, Waite and Calamaro, 2010). However, communication and interaction depends upon the ability of nurses to communicate and manage patients whose religion and culture are different from that of the nurses themselves. Thus, the ability of nurses to provide culturally competent health care is critical, particularly in a dissimilar cultural environment to their native ones. Furthermore, the ability of nurses to develop cultural competency to suit the health care context is imperative and can be done by understanding patients' culture and religion (faith and spirituality) and consequently meeting patients' needs (Flowers, 2009, Slettebo, 2008, Bonney, 2008, Choi et. al., 2001). It can be said that providing culturally competent health care leads to professionalism in nursing. Professional nurses may enjoy a long tradition of huge respect from patients if they demonstrate the acceptance of patients' cultures and beliefs (Hammer, 2003). While, nurses or doctors may not agree with their patient's religion and beliefs, they must take them seriously and recognise that holistic services, that are non-dogmatic and appropriate, are needed (Johnston, 1990).

According to Kirmayer and Minas (2000), a health care system will be ineffective and inefficient unless health care providers (i.e. nurses, doctors) in organisations (i.e. hospitals) understand culturally diverse communities, and are able to focus on learning about the strange culture that differs from nurses' cultural norms and faiths. This suggests that health care should be provided on the basis of patient's beliefs and desires. In this case, problems associated with different religious and cultural norms and values will be minimised. Therefore, nurses can then make a link between cultural competence and family and patient outcomes (Schin et al., 2007).

## **1.2 Research Problem**

As illustrated by the title of this thesis, this study targeted non-Muslim nurses working in Saudi hospitals. These hospitals aim to develop the successful integration of non-Muslim nurses, because they form about 80 percent of the total number of nurses in the hospital. Thus, hospitals' expectations are positioned in reference to nurses' attitudes and behaviours, as regards Islamic religion and Saudi culture. The hospital also expects that the health care provided to Muslim patients is not affected by nurses' original culture. Therefore, this study aims to investigate non-Muslim nurses' experiences caring for Muslim Saudi patients, with particular focus on Islamic religion and local Saudi culture. The experience of Muslim patients being cared for by non-Muslim nurses was also explored to highlight the relationship between religion and culture. The primary focus of the study is on religion and culture, because Saudi Arabia is a religiously conservative country, and religion influences all aspects of life. However, the study also considers wider cultural factors (O'Hagan, 2002).

Another assumption of the study, which is largely based on the experience of nurses in Saudi Arabia, is that religion plays a significant role in non-Muslim nurses' experience of care. This is because Saudi Arabia, in comparison to other Muslim countries, is religiously conservative, and religion plays a role in all aspects of Saudis' lives, particularly in relation to health. This means that patients' behaviours and attitudes are largely influenced by religion. It is, thus, conceivable that patients may have concerns about non-Muslim nurses being largely responsible for their care. Illness is very much a part of a Muslims' destiny, and has been ordained by God. During illness a Muslim depends on God to help them, and so increases supplications to God. Therefore, Muslim patients during illness are more dependent, more conscious and more God fearing. This leads to increased piety, which makes them more anxious about being cared for someone whom they perceive does not understand, or may not be overly concerned with, religious issues (Bonney, 2008, Congress, 2004).

### **1.3 Study Objectives and Questions**

On the basis of the research problem, this study aims:

#### **Objectives**

1. To understand, from the perspective of non-Muslim nurses what it is like to care for Muslim patients in Saudi Arabia in terms of religion and culture.
2. To explore from the perspective of Muslim patients what it is like being cared for by non-Muslim nurses in terms of religion and culture.

### **1.4 This study answers the following two questions**

1. Is religion a significant factor in the care relationship between non-Muslim nurses and Muslim patients in Saudi Arabia?
2. What are the implications for the training of non-Muslim nurses caring for Muslims patients in Saudi Arabia?

### **1.5 Rationale for the study**

Many people who work in the healthcare sector in Saudi Arabia are expatriate workers with varying different nationalities (Almalki et al., 2011). There has been a clear intention among the Saudi government to implement Saudisation and give more jobs to Saudis in all sectors including healthcare. According to the Ministry of Economy Planning (2010), the number of Saudi nurses is still below target; this is most true in the private sector. Almalki et al. (2011 p.304) states that Saudis only make up 29.1 percent of the total nursing workforce. Therefore, the nursing sector is still heavily dependent on expatriate nurses, many of whom are non-Muslim.

Saudi Arabia has a unique culture, and the fact that there are a large number of expatriate nurses with limited knowledge of culture contributes to the problem of providing culturally competent care (Almutairi and McCarthy, 2012). Expatriate nurses in Saudi Arabia, for the most part, have not significantly understood Saudi culture, and Islamic faith has affected the

quality of nursing care provided to Muslim patients. Equally, it is assumed that nurses working in Saudi Arabia have taken some courses on the cultural and ethical issues associated with working in other nations. Additionally, nurses may be exposed to training that gives them the opportunity to understand other religions and cultures', suggesting this is an important aspect of providing culturally congruent care, whereby nurses can then understand the needs and sensitivities of patients.

The findings of this study may also assist hospitals and other health facilities in Saudi Arabia to identify and overcome challenges and obstacles hindering the work of nurses, by conducting intensive training and orientation workshops on the importance of religion and spirituality for Muslims, as well as local Saudi culture and the importance of family to Saudis. This will also enable hospitals to develop approaches and mechanisms for integrating foreign nurses into Saudi culture and the social environment. This study will be beneficial when designing strategic objectives, not only for the target hospital in this study, but also for other hospitals that hire expatriate nurses. Saudi hospitals and health facilities may benefit from the recommendations made in this study and then be in a position to translate them into policy implications and action plans.

## **1.6 Theoretical background and framework**

One of the objectives of the study is to improve transcultural nursing in Saudi Arabia by understanding issues in accordance with nurses' experiences; therefore, issues of transcultural competence will be addressed. Moreover, the study is positioned specifically in reference to religion and culture in Saudi Arabia. Therefore, the extent to which these factors are relevant to cultural competence and the general experience of the care relationship is also important. Moreover, the study considers issues related to culturally competent care and examines specific issues within religion and culture, such as the spiritual needs and family ties that feature in the care relationship, and which are considered in the theoretical framework of this study. Thus concepts of religion, culture, language, nursing and cross-cultural care are considered to be crucial, and therefore underpin the theoretical framework used in this study.

The study aims to investigate the experience of non-Muslim nurses caring for Muslim patients in Saudi Arabia. It is anticipated that this experience will be affected by the strong religious and cultural factors that dominate in the context of Saudi Arabia. However, the study does not make assumptions about how religious and cultural factors feature in that experience, the research question simply asks: is religion a significant factor in the care

relationship? It may be that cultural and religious factors are significant in terms of cultural competence, because nurses are not properly trained for culturally congruent care in Saudi Arabia, or it may be that such religious and cultural factors are significant because they affect nurses' experience in other ways. Therefore, the theories and works of other authors are also introduced to provide insight into how cultural and religious factors feature in the care relationship and cultural competence in nursing.

Theories and models regarding transcultural nursing and culturally competent care are often provided as guidelines during nursing practice or to guide development in the context of training and education. Moreover, models are often used as a tool for assessing cultural competence. The field of transcultural nursing involves individual and group behaviours and considers the religion of patients as important for high quality care. Leininger, who was a prominent theorist in the field of transcultural nursing care, established this view. Working almost entirely independently, Leininger introduced the field of transcultural nursing, having formerly been involved in education, research and publishing (Rosenbaum, 1986). Her cultural care theory has influenced many nurses in their approaches to transcultural care, and she has actively encouraged nurses to employ transcultural nursing principles and practices in their work (Rosenbaum, 1986). This study aims to contribute to transcultural nursing care, by examining the experiences of non-Muslim nurses caring for Muslim patients in a religiously conservative society.

Leininger emphasises care in nursing, in that it is the essence and unifying feature of nursing. Although care is a universal phenomenon, it varies among cultures and presents itself in different ways in terms of processes, expressions and patterns. Leininger (2010) focuses attention on the relationship between culture and its significant contribution to the quality of patient care. This explains why this theory is considered appropriate to this study; i.e. because it is concerned with attaining an understanding of culture as a means to improving patient care. Similarly, the study is concerned with understanding religion and its impact on patient care, in a specific context, with a view to improving the quality of patient care. Healthcare workers are more than simply carers; their duties extend beyond simple care; therefore, in order to practice effectively they must understand religious and cultural issues.

From the outset of her research in this area, Leininger worked on developing the 'Sunrise model', in relation to her theory. The model is useful for understanding the health needs of patients in relation to areas such as religion and family ties. Importantly, the model was

developed as a conceptual guide, intended to help researchers identify theoretical aspects that need to be considered in the context of transcultural nursing research. Moreover, because the model can be used by nurses to assess the cultural or religious needs of patients, it also provides a basis for examining nurses' experience in terms of their ability to provide culturally congruent care. The model is also broad in terms of the factors it considers in reference to culturally congruent care; these include cultural values, beliefs and practices, religious or spiritual beliefs and family and social factors, all of which are deemed relevant by Muslim patients in Saudi Arabia. In relation to this, Rosenbaum (1986) recommended that researchers may wish to study phenomena related to some of the components of the Sunrise model, i.e. religious and philosophical factors, kinship and social factors and cultural factors. This is a suggestion that the approach in this study will follow.

Giger and Davidhizar (1990) developed another model of interest; this is the Transcultural Assessment Model. Their model was intended for use with nursing students, helping to insure their ability to provide transcultural care. The model is based on the idea that although not all cultures are the same, they are subject to the same organisational factors. The model includes six cultural phenomena that vary across different cultures and have an impact on care transcultural nursing, culturally competent care, and culturally sensitive environment; three of these are social organisation, communication, and space (referring to the physical proximity between people). These factors are relevant to cultural competence but are also relevant to the experience of care in a cross-cultural setting. The model postulates that people are culturally unique and should be assessed according to cultural phenomena.

This model is included in the theoretical framework for this study, because it recognises specific aspects of people's culture that are of relevance to the study context. Although the model is not used as an assessment instrument, for example, to assess the transcultural competence of the nurses against the six cultural phenomena, it provides insight into the areas that are of importance to transcultural care. More specifically, the model provides specific dimensions that are relevant to this study; i.e. communication between non-Arabic speaking expatriate nurses and Muslim Saudi patients, physical space between nurses and patients and the violation of that space, the role of family, and religious beliefs. One of the assumptions incorporated into the model is that these values, beliefs, norms and practices are shared within a cultural group (Giger and Davidhizar 2002). Therefore, the model can usefully be applied to the study context, as it relates to the experience of caring for patients from the same cultural group, i.e. Saudi Arabians.



## **1.7 The Study Area**

This section introduces some of the characteristics of Saudi Arabia, focusing on healthcare and the structure of healthcare services in Saudi Arabia, and also provides an overview of the hospital in which the study was conducted.

### **1.7.1 Saudi Arabia**

Saudi Arabia is the largest country in the Middle East with a total land area of 2,250,000 square kilometres. The economy is primarily dependent on the country's vast oil reserves, which are the largest in the world (Walston et al., 2008).

Saudi Arabia is home to the two holiest sites of Islam, Mecca and Medina. The King is also the custodian of these two holy mosques. The modern state of Saudi Arabia was established in 1932 by Abd Al Aziz bin Abd al-Rahman Al Saud (Ibn Saud). The Kingdom adheres to Sunni Islam, and it has endeavoured to pursue an inter-faith dialogue, supported by an initiative in December 2005 by King Abdullah; the idea of which is to promote religious tolerance.

There are a large number of expatriate workers in Saudi Arabia, many of whom are not Muslim. Their presence in the Kingdom has no impact on the societal and ethical behaviour of locals because there is no interaction between expatriate non-Muslims and Saudi Muslims beyond the working relationship (Vidyasagar and Rea, 2004). Expatriate nurses in Saudi Arabia often live in compounds, which provide a 'world-within-a-world, a self-contained retreat from the idiosyncrasies of life in the KSA' (van Rooyen et al., 2010 p.4). When expatriate nurses arrive in Saudi Arabia they often feel isolated and seek out support networks within the expatriate community, or rely on contact with friends and family back home (van Rooyen et al. 2010). The healthcare setting is important on relation to this divide, as within healthcare, normal separation is not possible; Muslim patients, who would not normally interact with non-Muslim individuals, are forced to do so in circumstances of 'ill health'. This schism between expatriate nurses and Saudi patients presents a risk for the nurses that their own 'cultural safety' will be compromised.

There has been a significant decrease in net migration into the Kingdom since 2000 (Agency, 2011) as a result of Saudisation, a program to increase Saudi employment and to decrease dependence on foreign labour. More recently, the Saudi government announced an initiative restricting expatriates from working in the Kingdom for a maximum of six years as part of the Saudisation policy (Arab News, 2011). The emphasis on Saudisation is of particular interest in relation to nursing because many female nurses are expatriates. This is because it is culturally and socially unacceptable for a Saudi female to become a nurse (Tumulty, 2001). It is therefore difficult to see how Saudisation policies can be effectively implemented for nursing.

In terms of education, there are issues for women in Saudi Arabia. Although Islam sanctions the rights of men and women to acquire knowledge there are restrictions on what knowledge women are permitted to learn. In addition, distance learning is encouraged. Despite these facts, Saudi women are now more educated than Saudi men because providing females with an education has been a high priority for the government (Vidyasagar and Rea, 2004). However, in relation to nursing, Saudi women are less likely to join nursing education due to cultural factors (see section 2.11 Gender Issues).

### **1.7.2 Healthcare in Saudi Arabia**

There are two major factors influencing health services in the Kingdom. Firstly, there are many foreign workers, and secondly, there is a very large young population. It has been suggested by Walston et al. (2008) that these demographics will affect the future direction of the Saudi health service.

Healthcare in Saudi Arabia is a basic right entrenched in Saudi law, and is provided to all Saudi citizens free of charge. A corresponding fact is that the use of private medical insurance is very low (Walston et al., 2008).

The development of healthcare in Saudi Arabia, much like other public services, has been closely linked to the economic success of the Kingdom as a major oil exporter. This wealth has led to little economic restraint, with the healthcare service being given a boost because of its ability to acquire the latest technology (Gallagher and Maureen Searle, 1985). The Kingdom's immense oil wealth has afforded opportunities to educate the Saudis and provide highly advanced technical medical services (Tamim et al., 2010).

Another important aspect of healthcare in Saudi Arabia is that annually, during Hajj, free healthcare is available to more than five million pilgrims, who visit the Holy Mosque in Mecca. In 2005 more than 250,000 pilgrims were treated in 22 Ministry of Health assigned hospitals and 165 health centres (Walston et al., 2008).

There are three main outlets through which healthcare is provided in the Kingdom: the Ministry of Health hospitals and healthcare centres, the private sector and other governmental institutions (Walston et al., 2008). These institutions include the military, the National Guard, university hospitals and large corporations, such as Aramco (Al-Yousuf et al., 2002).

It has been suggested by Gallagher and Searle (1985) that social, cultural and political factors have shaped the healthcare services of countries, and that when applying this principle it should be remembered that Saudi Arabia is a very conservative society in which social change and technological advancement are shaped by Islamic cultural values.

In terms of ethical issues, the hospitals in Saudi Arabia make decisions in the same way as those in the West. However, the difference is that none of these decisions are allowed to contravene the teachings of Islam. There has been concern that globalisation will erode these beliefs and values, although these claims may be unwarranted as cross-fertilisation of cultures will enrich Saudi culture without eroding it (Tamim et al., 2010).

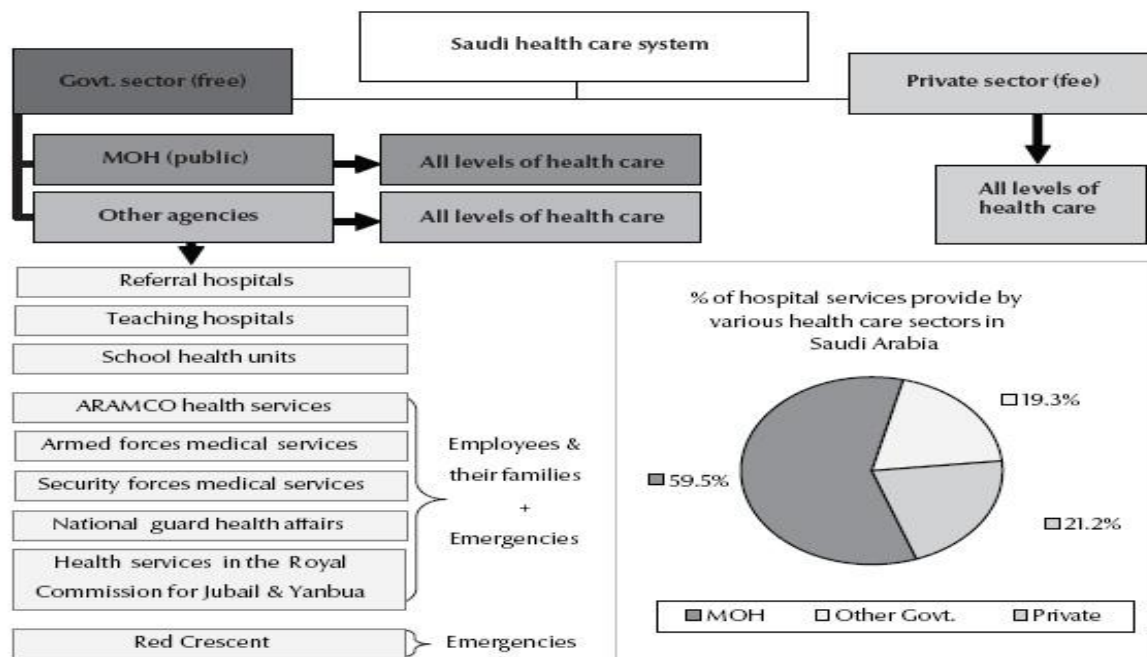
### **1.7.3 Structure of healthcare services in Saudi Arabia**

The Ministry of Health (MOH) in Saudi Arabia is the government body responsible for providing and financing the majority of the healthcare services in the Kingdom. There are 244 hospitals and 2037 primary healthcare centres under the authority of the MOH, covering about 60 percent of healthcare services (Almalki et al., 2011). Under the government there are also referral hospitals (of which the KFSH&RC is one), army and security forces hospitals, National Guard hospitals, and teaching hospitals, which fall under the Ministry of Education and the Red Crescent Society. However, apart from the KFSH&RC and other referral hospitals, the teaching hospitals and the Red Crescent hospitals, the other hospitals provide services to their own populations (Almalki et al., 2011).

The remit of the MOH includes planning, formulating and managing health policies (Almalki et al., 2011). The MOH is also responsible for advising other government healthcare bodies and the private sector on how to implement national healthcare policies (Mufti, 2000). The country is divided into health regions, which the MOH of health supervises. However, these

regions enjoy a degree of autonomy, and MOH services are decentralised in these regions because the management of resources is more effective at the local level, and so this decentralisation is part of the overall development policy in the country (Mufti, 2000).

**Figure 1: Current structure of the healthcare sector in Saudi Arabia**



(MOH=Ministry of Health)Source: *Almalki et al. (2011 p.786)*

Unfortunately, because of the multiplicity of healthcare providers, there is poor coordination and communication between them, which has resulted in a waste of resources and a loss of the opportunity to combine resources. Although there have been efforts to rectify this problem, such as the establishment of the Council of Health Services in 2002 to help integrate services, there has been little progress in this area (Almalki et al., 2011).

#### **1.7.4 King Faisal Speciality Hospital and Research Centre (KFSH&RC)**

The KFSH&RC, the location for this study, was established in 1970. In 1973 the hospital commissioned the Hospital Corporation of America (HCA) to administer and operate the hospital, an arrangement that ended in 1985 when the hospital was transferred to a national team ([www.hziegler.com/employers/king-faisal-riyadh.html](http://www.hziegler.com/employers/king-faisal-riyadh.html), 2011). The hospital specialises in tertiary care and only takes patients on a referral basis. Moreover, the hospital has the latest medical equipment and performs advanced procedures such as open-heart surgery and kidney transplants; it is also the main referral hospital for cancer treatments, and receives requests from overseas for treatment (Mufti, 2000).

The hospital currently has 936 beds and 18 medical departments. There is a total of 6,946 staff representing 63 different nationalities. There are 703 medical staff, of which 46 percent are expatriates, including 16 percent from the United States and Canada and 11 percent from Europe. On average, 32,000 patients are referred to the hospital annually (KFSH&RC, 2012). There are a total of 1,942 nurses, 18 percent of whom are from Canada and 11 percent of whom are from the United States. The remainder are from Saudi Arabia, the UK, Europe, New Zealand, Australia and the Philippines (KFSH&RC, 2012).

The KFSH&RC specialises in research and the advancement of scientific knowledge in all disciplines associated with the biomedical sciences (KFSH&RC, 2012). Therefore, it is clear that the hospital is a multi-cultural society, contrasting with the population of Saudi Arabia itself, which is predominantly homogenous and Muslim.

## **1.8 Key concepts in the Kingdom of Saudi Arabia context**

This study was conducted in a hospital environment in Saudi Arabia, and the participants were both Muslim patients and non-Muslim nurses. There are a number of key concepts of relevance to the study, including the terms Islam, culture and transcultural-culturally competent care. These key concepts have been introduced and then made relevant to this study.

### **1.8.1 Islamic faith (religion)**

Islam requires submission to the will of God, and was revealed to the last prophet, Muhammad (pbup). The fundamental belief of Islam is that there is only one God, who has no partner, and with whom no one shares divinity. Other essential tenets of the faith include belief in the angels, revealed books, messengers and prophets, and the day of resurrection and destiny (Ibrahim, 1997). The latter is relevant to this study, as Muslims believe in destiny, and therefore any illness that befalls them is from God, either as a punishment or an expiation of sin. It is not befitting for a Muslim to complain of illness to anyone except God.

The teachings of Islam cover all aspects of life, and thus Islam is considered a complete way of life. There are two main sources of teaching, the Holy Quran, divinely revealed by the Archangel Gabriel to the Prophet Muhammad (pbuh) and the life and teachings of the Prophet himself. These teachings cover areas such as economics, justice, family issues, health and medicine, as well as the daily acts of worship.

Saudi Arabia is the heartland of Islam because it hosts two of the religion's holiest sites: the Holy Kabah in Mecca and the Prophets mosque in Madinah. The country is considered to be the birthplace of Islam, and the last prophet Muhammad (pbuh). Moreover, Saudi Arabia implements Shariah law and Islamic corporal punishment (hudud). The religion is adhered to very strictly in the Kingdom, and is highly instrumental in shaping the culture, including hospitality and acting honourably to guests and showing politeness and manners.

Because Islam is a central tenet of Saudi society and the private lives of Saudi citizens, it is apparent that sensitivity to such beliefs is paramount in the nurse-patient relationship. Issues considered relate to the privacy of the patient, understanding of cultural sensitivities and understanding of the patients' perception of their situation are essential when providing culturally congruent care. For these reasons religion, Islam, is a key concern of this study.

### **1.8.2 Culture**

One of the earliest and clearest definitions of culture was provided by Sir Edward Burnett Tylor in 1871, in his book *Primitive Culture*. This provided the first modern anthropological definition of culture: "Culture or civilization, taken in its wide ethnographic sense, is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society" (Noble, 2010, p.11).

Culture includes all the beliefs that a person has, their practices and rituals, and what they have inherited from previous generations. Culture also incorporates people's race, ethnicity, gender, religion, and socio-economic status (Nurses-neighborhood, 2011).

The most popular understanding of culture expects a high level of uniformity within a particular social system; however, more recently understanding of culture has been less bound by only ethnicity or nationality and has accepted that common cultural characteristics may now be attributed to many different social groups of different sizes, for example "the liberal values of the Christian-European West"(Bolten et al., 2009 p.35)

It has been suggested by Birukou et al. (2009) that culture has become less bound to a geographical area, race or religion because of globalisation, and that multi-national organisations need to consider this when providing products and services. However, when we consider culture in this way, i.e. understanding culture as an expression of coherence, contradictions arise. For example, in reference to liberal values a contradiction becomes

apparent when we meet someone with dictatorial tendencies who happens to be a European (Bolten et al., 2009).

There has been variation in what is considered to constitute a cultural barrier. In a study by McBain Rigg and Veitch (2011), about cultural barriers to healthcare for Australian aboriginal people, it was discovered that cultural barriers were perceived differently by healthcare workers and Aboriginal patients. Whilst the latter were more concerned with relationships, respect and trust, the former were more interested in making the aboriginal patients comfortable with the changes in their environment and exposure to new systems. They were less concerned with interpersonal relationships, even though establishing a strong personal relationship with healthcare workers was paramount to Aboriginal patients.

Not only does culture affect the nurse-patient relationship but it has also played a significant role in shaping the current situation effecting nursing in Saudi Arabia. It is not that Saudi Arabia does not have the will or resources to train local Saudis as nurses; it is directly because of Saudi culture that locals are discouraged from entering the nursing profession. A female who works as a nurse is often looked down upon because she has to mix with members of the opposite sex and work unsociable hours; moreover, women will not enter the nursing profession for fear that they will not attract suitors for marriage. It can be seen therefore, that culture is a key concept within the context of Saudi Arabia and of huge relevance to this study.

### **1.8.3 Language**

A further key concept discussed in this study is language. Language consists of a shared system of words, punctuation and grammar. Problems associated with communication arise when code switching from one language to another, i.e. translation, fails, leading to misunderstanding or misinterpretation (Seleskovitch, 1976). In the presence of a qualified interpreter, the satisfaction level of patients in the care relationship increases.

Because of globalisation countries around the world are experiencing an increasingly culturally and linguistically diverse workforces; this is especially the case in Saudi Arabia's hospitals, where expatriates from a multitude of different countries constitute a large percentage of the nursing contingent. Although, one of the most universal languages used in

the world is English it is not spoken by many Saudis, the main language used is Arabic. This poses an additional difficulty, and can be a barrier to providing good quality care to patients.

The patient carer relationship can be inhibited if the patient has limited language abilities, potentially reducing their access to preventative health, decreasing their satisfaction with the healthcare received and increasing the risk of misdiagnosis (Diamond and Jacobs, 2010). This was asserted by Ferguson and Candib (2002), who stated that good quality healthcare and a rapport between the patient and the healthcare provider cannot be established until differences in culture and language are overcome.

There has been evidence in Saudi Arabia that language barriers are an issue. In a study by Suliman et al (2009) on patients' perceptions and level of satisfaction with care in Saudi Arabia, it was found that staff nurses were incapable of delivering effective care to patients because of language barriers and cultural differences. However, there has been evidence that if clinicians learn the basics of the language relative to healthcare concerns then this may actually lead to healthcare disparities for those patients with limited language abilities (Diamond and Jacobs, 2010).

Narayanasamy (2003) says that a sensitive approach to patients' needs is an essential part of transcultural care, part of this is using a familiar language. If there are differences in language this can lead to prolonged treatment; this has led the Royal College of Nursing to recommend proper translation services are put in place. The negative issues associated with language differences are made worse in Saudi Arabia because of multinational workforces in hospitals, even nurses from English speaking backgrounds use English in different ways. Moreover, language barriers between nurses and patients lead to nurses feeling frustrated because care takes longer, even non-Verbal communication is an issue because of women covering their faces making it also difficult to establish relationships (van Rooyen et al., 2010).

#### **1.8.4 Nursing in Saudi Arabia**

Nursing in Saudi Arabia has been characterised by low participation from Saudi nationals. In a study by Al Ahmadi (2002) about nurses working in government hospitals in Riyadh, only 16 percent were Saudi, 71.3 percent were from South East Asia, 8.6 percent were from other Arab countries and 0.5 percent from Western nations. However, more recently the number of Saudi nurses working in MOH hospitals in Riyadh has increased, in 2008 there were 4778 Saudi nurses compared to 6718 non-Saudi nurses (Ministry of Health, 2008). This represented a rise from 23.9 percent to 28.8 percent in the period 2004 to 2008, due to



Saudisation (although in the private sector only 4.5 percent of the workforce was Saudi (Planning and Arabia, 2010)). These figures illustrate the continuance of a significant reliance on non-Saudi nurses, who El-Gilany and Al-Wehady (2001) suggest may consider themselves merely as hired functionaries, lacking in the enthusiasm necessary to make creative contributions in the workplace.

These figures reflect the fact that there is a serious nursing shortage through lack of enrolment in nursing courses in the Kingdom; this has been a problem for some time. However, the aforementioned factors related to Saudi Arabia may not be the only factors of relevance; Al Omar (2004) alleges that the shortage of nurses is a global problem. On a global scale there are problems with the image of nursing; although students perceive that nursing provides a good income and job security there is a negative image about its prestige and limited opportunities for independent work in comparison to other professions (Duvall and Andrews, 2010). Despite these factors Islamic clerics in the Kingdom list nursing as one of the recommended professions for women (Vidyasagar and Rea, 2004).

Although in Saudi Arabia there is strict gender segregation throughout all levels of education including university, and this is also found in the healthcare sector where mixing between genders is kept to a minimum in the patient-provider relationship, males and females working in healthcare are expected to interact with each other as co-workers (Carty et al., 1998). Hospitals are the only place that Saudi employment law permits men and women to work together (Vidyasagar and Rea, 2004). However, in a study by El-Gilany and Al-Wehady (2001) 98.3 percent of female Saudi nurses in Saudi Arabia said they would not agree to care for male patients.

Another way that entering the nursing profession is affected by Saudi Arabian culture is that there is much emphasis placed on family life, meaning that it may be perceived by some as unacceptable to work in an occupation that requires shift work and being on call all year (Carty et al., 1998). In fact, in a study by El-Gilany and Al-Wehady (2001) although there was a high degree of job satisfaction, nurses preferred to be one-shift duty. Additionally, healthcare professions have not been held in high regard in Saudi Arabia. According to a study by Mansour (1992) there are a number of reasons why parents do not approve of their children training to work as nurses; these reasons include social image, working hours, and free mixing with the opposite gender; these views are shared almost equally by parents and students. Interestingly, however, 88.2 percent of parents in this study, Mansur said there was

a clear need for Saudi nurses, because they are better able to understand the culture and psychology of the patients, and better able to communicate and be more loyal to Islamic values. However, reluctance to enter the nursing profession was also reported by Al Omar (2004), who found only 5.2 percent of Saudi women would wish to enter nursing. The main deterrent mentioned in this study was the perception of greater workloads in nursing than in other professions.

In a study by Shukri (2005) it was found that one of the main problems with nursing in the Arab world is that there is no single entry level criteria for nursing training. The range varies widely, from a high school education to a baccalaureate, although in most Arab countries the most commonly accepted qualification for entry into the nursing profession is a diploma. In fact, for the countries of Northern Africa a baccalaureate is not even available. Saudi Arabia offers up to the level of a Master's Degree in nursing (Shukri, 2005) and to date does not offer Doctoral level study.

It is important to note that there is a high level of understanding of the role of nurses in Saudi Arabia, and improved understanding, combined with a better attitude toward nursing would be more likely to improve the uptake of the profession (AL-OMAR, 2004). El-Gilany and Al-Wehady (2001) suggest that the unfavourable situation, whereby there is a shortage of people entering the nursing profession can be alleviated by improving working conditions and job satisfaction.

However, it has been shown there is a high degree of job satisfaction among nurses in Saudi Arabia. In a study by El-Gilany and Al-Wehady (2001) it was found that 92 percent of nurses were satisfied with their work. Although, according to (Al-Ahmadi, 2002), overall job satisfaction for nurses working in Riyadh was moderate and it reported that factors such as gender, age, income and nationality made no difference to the results, the only significant factors affecting satisfaction were level of education and years of experience.

The social attitude towards nursing in Saudi Arabia can have an impact on job satisfaction, because, as found in a study by El-Gilany and Al-Wehady (2001), to improve satisfaction social attitudes have to be improved.

This study is about understanding the experience of non-Muslim nurses caring for Muslim patients in Saudi Arabia and the issues they encounter. One senior British nurse commented that many Western nurses are timid and sensitive to the religious sensibilities of patients, and

that these imagined sensibilities be detrimental to the care afforded to patients; on the other hand, it has also been found that expatriate nurses are better at predicting Saudi patients' responses to socio-medical issues than Saudi physicians (Tamim et al., 2010). This study therefore, will seek to examine and shed light on cross-cultural interactions and their impact on cross-cultural care.

### **1.8.5 Cross-culturally competent care**

Betancourt et al. (2002 :3) describe culturally competent care as the “ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural, and linguistic needs”. The necessity of this approach to care has arisen from an increase in racial and ethnic diversity within society as a result of globalisation; it is also a vehicle which improves the quality of healthcare.

Simply recognising a cultural characteristic in their patient does not necessarily mean that a nurse is actively practising cultural care. However, upon closer examination, it is evident that patients' cultural needs are interpreted and responded to by nurses within a restricted frame of reference (Narayanasamy, 2003).

In relation to Muslim patients specifically, a study by Hasnain et al (2010) revealed a very high percentage, 83.3 percent of healthcare providers, 93.8 percent of Muslim female patients, felt that they encountered challenges in the healthcare relationship. The patients also commented that healthcare providers did not appreciate their cultural or religious needs, with both parties reporting similar barriers and recommendations, the most prominent of which were issues related to cultural and religious sensitivities, and communication barriers related to language difficulties and patients' modesty requirements. For healthcare providers it was patients' failure to understand diseases and healthcare processes, which were believed to be most important.

Moreover, there is the issue of discriminatory behaviour when providing nursing care. According to Narayanasamy (2003), there is a need for equal access to care, and racial discrimination is an obstacle to providing care to ethnic minority groups. Although Muslim patients in Saudi Arabia are not an ethnic minority, nurse's ethnocentric cultural bias and attitudes can create significant barriers to health care provision, as the majority of nurses are non-Muslim, while the majority of patients are Muslim.

## 1.9 Glossary of main concepts used in the study

This section summarises the main concepts introduced in the study.

Culture	“Culture or civilization, taken in its wide ethnographic sense, is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society” (Noble, 2010: 11).
Transcultural	“A substantive area of study and practice focused on comparative cultural care (caring) values, beliefs, and practices of individuals or groups of similar or different cultures with the goal of providing culture-specific and universal nursing care practices in promoting health or well-being or to help people to face unfavourable human conditions, illness, or death in culturally meaningful ways” (Leininger (1995: 58)).
Cultural competency	“Ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients’ social, cultural, and linguistic needs” (Betancourt et al., 2002: 3).
Language	Language consists of the shared system of words, punctuation and grammar. Problems associated with communication occur when code switching from one language to another, i.e. translation fails, which leads to misunderstanding or misinterpretation (Seleskovitch, 1976).
Respect	Browne (1997) mentions that the term “respect” is critical in nursing. However, respect may have different meanings to different individuals, depending on culture or age. Respect can be an abstract term such as an appreciation or recognition or an extension of esteem. Therefore, respect may be regarded as a condition, such as an attitude or any expression of appreciation for someone (Shepherd and Fazakerly, 2000). Burkhardt and Nathaniel (1998) document respect from the point of view of ethical and

	nursing principles, and state that respect is the core of added value in personal care.
Patient safety	Quality of care is the degree to which health care services for individuals and populations, increase the likelihood of desired health outcomes and offer care consistent with current professional knowledge.
Spirituality	Concerned with our ability, through our attitudes and actions, to relate to others, to ourselves, and to God, as we understand Him.

## 1.9 Thesis structure

The thesis is divided into six chapters. The introductory chapter provides an overview of the study and the importance of the need to investigate non-Muslim nurses' experiences of caring for Muslim patients in Saudi Arabia. There is an explanation of the author's rationale in designing the study, and determining its theoretical framework. The study setting is also presented, introducing the national hospital setting, expatriate nurses in Saudi Arabia, Islam and culture as well as transcultural nursing.

Chapter Two provides a review of the literature and covers all relevant areas of the study, revealing issues that are critical for the development of the methodology. This includes areas related to religion and spirituality, nursing and healthcare, culture and language and those affecting the Saudi context.

The third chapter sets out the methodology and justifies the phenomenological interpretive approach to the research. More specifically, it explains how the research is set within an (interpretive) phenomenological paradigm, as introduced by Heidegger. It considers and explains the rejection of other methodological approaches. This chapter provides justification for adopting a post positivist approach and explains why it has rejected positivism.

Chapter Four presents an analysis of findings. The chapter begins with a presentation of the profile of nurses and then continues with an analysis of the findings following interviews with nurses. Emerging themes are presented in this chapter and are structured around religion, culture, language and training and orientation. The analysis of the findings from patients is also presented in this chapter and emerging themes are also identified.

Chapter Five is the discussion chapter, and in it, themes that have emerged from the study are discussed in relation to existing theories and ideas in the literature. Moreover, the discussion also explains how the findings offer a new contribution to the area of transcultural nursing.

Chapter Six presents the conclusion and recommendations, and discusses the implications of the research for future nursing practice and research; finally, the limitations of the study are discussed.

## **CHAPTER TWO: LITERATURE REVIEW**

### **2.1 Introduction**

The purpose of a literature review is to identify, analyse, assess and interpret existing literature related to a particular topic. Alongside this, it should also establish the context and rationale for the research study, by revealing any existing gaps in the literature. It should also detail the approach taken by other scholars working on the same topic (Jones, 2007). Sources for a literature review can include journal articles, books, papers and reports.

### **2.2 Search method**

From the outset, the author sought out literature relating to nursing, transcultural care, cultural competence, caring for Muslim patients, nursing in Saudi Arabia, language barriers and transcultural nursing education. These topics relate to the aims and objectives of the study.

A number of databases were used in the literature search, including Medline, CINAHL, the British Nursing Index and Google Scholar. The criteria for this search were that the literature had to be post-1990 (although literature before this date was accepted if it was important to the study), be written in English, and be qualitative in nature. Most of the literature that was reviewed consisted of journal articles and books, which together represented the main texts in the relevant subject areas.

Literature was reviewed throughout the entire duration of the study, to ensure that any new developments in transcultural care and other relevant areas were included.

**Table1: Databases used in the Literature Review**

<b>Keywords</b>	<b>Medline</b>	<b>CINAHL</b>	<b>British Nursing Index</b>	<b>Academic Search Premier (EBSCO)</b>	<b>Google Scholar</b>
Religion and Healthcare	502	242	5319	937	81300
Islam and Healthcare	131	54	2593	167	26400
Islam and Nursing	266	239	916	103	31200
Transcultural Nursing	3102	2994	1774	1071	22200
Culturally Competent Care	569	643	3288	337	108000
Healthcare and Saudi Arabia	184	58	7828	290	37300
Saudi Arabia and Nursing	318	222	1244	124	19300
Expatriate Nurses and Saudi Arabia	6	6	337	2	1420
Language Barriers and Healthcare	139	79	8084	283	139000
Nursing and Muslim Patients	20	31	604	34	15900
Culturally Sensitive Care	419	428	6846	236	234000
Transcultural nursing and Education	1162	884	551	265	16500



**Table 1: MeSH**

<b>Search Terms</b>	<b>Results</b>
Religion AND Delivery of Health Care	<b>37</b>
Islam AND Delivery of Health Care	<b>18</b>
Islam AND Nursing	<b>2</b>
Transcultural Nursing	<b>2158</b>
Cultural Competency AND Delivery of Health Care	<b>34</b>
Saudi Arabia AND Delivery of Health Care	<b>24,582</b>
(MM "Saudi Arabia") AND (MM "Nursing")	<b>0</b>
Expatriate Nurses and Saudi Arabia	<b>0</b>
Communication Barriers AND Delivery of Health Care	<b>36</b>
Nursing and Muslim Patients	<b>No Muslim, only Islam search</b>
Culture AND Delivery of Health Care	<b>122</b>
Cultural Competency AND Education and Nursing,	<b>9</b>
Religion and Medicine AND Islam	<b>272</b>

### **2.2.1 Inclusion Criteria**

Although the most recent material was sought for the literature review, no limits on date were set, as much of the material relating to the fundamental principles of transcultural nursing care was published several years ago. Only articles with recognised research methods were included in the results.

### **2.2.2 Sifting**

During the process of searching for articles in the databases, the first level of sifting involved excluding any articles whose titles were not pertinent to the study. Thereafter, the abstracts of the remaining articles were read to determine their relevance. If the abstracts suggested that the article would be relevant, then the rest of the text was considered, with particular attention being paid to the method, discussion and conclusion.

### **2.2.3 Trends in the Literature**

Some difficulty arose in the search for literature relating to the Saudi context, especially in relation to expatriate nurses, despite an abundance of material being found pertaining to other

areas in the world. However, few studies have addressed the relationship between religion and the cultural traditions in local societies in depth (see 6.2 Contribution to Knowledge). Sources relating to the experiences of expatriate nurses caring for Muslim patients in general, and Muslim patients in Saudi Arabia specifically were scarce. In the case of the latter, the literature tended to address the wider context of Saudi Arabia, including life outside of the hospital, rather than focusing specifically on the experience of caring for Muslim patients by non-Muslim nurses.

### **2.3 Key Understanding**

Caring for other people is a specialist area that requires patience and devotion. Halligan (2006) states that caring is a critical part of nursing, and is also intrinsic to health institutions that are now the locations of a wide range of cultural activities.

The word ‘health’ has different meanings in different cultures. Johnson (2001) cites Khayat’s (1999) Islamic definition of health, which suggests that it embodies spiritual as well as physical and psychological aspects. With this in mind, within the Saudi context, where we have to consider both religious and traditional boundaries, this study proposes that expatriate nurses who care for Muslim patients need to be aware of practices such as prayers and fasting in Ramadan. Therefore, nurses are required to be educated and trained in different important Islamic teachings and practices, as well as in language and cultural norms (i.e. family, relatives, and friends). Johnson (2001) observes that changes in the NHS during the 1990s brought about new challenges and opportunities for people of other religions. In supporting this argument, Maier-Lorentz (2008) suggests that transcultural care has become an important element in modern multicultural societies.

Since Saudi Arabia is a religiously conservative country, there is a need to discuss nurses’ experiences in this specific religious and cultural context, with a view to improving transcultural nursing care. The present study explores key themes that are relevant to this context, and details the research previously undertaken by experienced researchers. More specifically, the relevant literature is reviewed with a particular focus on key areas such as transcultural care, cultural awareness and religion and spirituality, which lie within the aims and objectives of the study.

## 2.4 Care and Caring

Researchers have long recognised that there is a problem in providing a definition of care in nursing. Several different approaches to this idea are proposed in the literature. Firstly, the literature demonstrates that an understanding of care and being able to recognise different levels of care is essential for nurses if they are to achieve competent standards for nursing care. In other words, there is a link between the understanding of care and measuring standards of nursing care. Related to this idea, Dyson (1996) suggests that the absence of a widely accepted or agreed definition of these concepts means that a standard of care cannot easily be established. Bassett (2002) concurs with this idea, proposing that since care is widely seen as the central element of nursing, nurses, who understand what care is, are the ones who can best evaluate quality patient care. Although Coulon et al. (1996) maintain that excellence in nursing care has not yet been properly defined and is an elusive concept, their study does provide some insights into care, demonstrating that excellence in nursing care is related to the nurses' personal qualities, the nurse-patient relationship, the nurses' humanity and the relationship between the nurse and the health team.

Bassett (2002) has addressed this issue more directly, suggesting that although it is difficult to define care and caring, it could be said that care is the unifying core of nursing, and that having a good understanding of care is linked to nurses' perceptions of their role. It is therefore essential that nurses find a good working definition of care, and an understanding of care, if they are to be responsible and accountable for their level of care.

A different approach to measuring care was proposed by Watson (2009). The author suggests that there has been a recent move or return to 'heart-centred love and caring' that has resulted from the emergence of 'Caring Science'. Caring Science includes the theoretical, philosophical and moral aspects of nursing (Watson, 2009). In contrast, 'relationship-based care' (Woolley et al., 2012) suggests that caring and healing environments involve three important relationships, namely those between the self (that is, the nurse), the patient and the patient's family, and the co-workers (doctors, nurses, etc.). This approach to the concept of care is more comprehensive as it considers other participant factors in the care relationship. Woolley et al. (2012) present a 'Relationship-Based Care Model', which, like Coulon et al. (1996), focuses on the patient, the patient's family and a framework of leadership; however, the model also considers more organisational factors such as teamwork and resource-driven

practice. This is relevant to this study since it is likely to affect the experience of care for the nurses and the patients, as well as offering a more practical approach to care.

In conducting this study, it is important to understand that the concept of care differs between cultures. According to Meng et al. (2011: 1523), the ‘expressions, dimensions and patterns of caring vary in different cultures’. In Chinese culture, for example, nurses are told to care for patients as if they were family members, although Meng et al. (2011) also assert that it is not enough to simply say this; instead, caring must be placed in a practical context. This concurs with Woolley et al. (2012), who suggest that care is achieved through professional nursing practice and patient care delivery. Ahmed (2008: 35) states that ideas about health, disease and sickness are subject to cultural connotations and personal experience that differ between cultures.

Meng et al. (2011) continue to provide an insightful definition of care, arguing that caring is a synthesis of four categories, which include attitude, knowledge, ability and perceptions. Attitude refers to a combination of professional responsibility for the provision of care and a humanitarian belief in its importance. Knowledge is a prerequisite for providing care and includes professional nursing knowledge. Ability relates to the skills and techniques required to exhibit caring behaviour; this includes the ability to perceive and comprehensively analyse patients’ needs. It also pertains to sympathising with patients and having empathetic insight. Finally, perception concerns a nurse’s sense of being cared for by others, as experience of care can in turn promote caring behaviour.

## **2.5 Transcultural Nursing**

The authors in this field acknowledge the basic notion that culture should be considered, understood and implemented in nursing care. Transcultural nursing has its roots in philosophical as well as theoretical perspectives. The philosophy of transcultural nursing, as identified by Leininger (1997), is based on the idea that health-care workers are more than simply carers, and should be equipped with the tools for understanding cultural and ethical issues related to patients. Leininger (1995: 58) defined transcultural care as:

*A substantive area of study and practice focussed on comparative cultural care (caring) values, beliefs, and practices of individuals or groups of similar or different cultures with the goal of providing culture-specific and universal nursing care practices in promoting health*

*or well-being or to help people to face unfavourable human conditions, illness, or death in culturally meaningful ways. (p. 58)*

Although Leininger's definition has been widely used by researchers, it has also been subject to much criticism. One of the main criticisms was raised by Nina Bruni (1988), who was working as a nurse in Australia. In her book on nursing, Bruni (1988) criticised transcultural nursing and accused Leininger of freezing the culture of other ethnic nations (groups). Her dislike of the transcultural theory focussed on the fact that the traditional approach of the theory leads to nurses developing a new culture that would build on other cultures. In general, the transcultural theory was described as a 'static' method that centres on individuals' ethnic origins or biological racial groups. However, Mulholland (1959) reminded us that people all over the world are also usually affected by other factors, including socio-economic systems. It is clear from the discussion in Mulholland (1959) that Mulholland supported Bruni's critiques of the transcultural approach of nursing and also considered it to be problematic, particularly in terms of conceptualising the term 'culture'. In relation to this aspect, Mulholland (1995: 446) states: "[T]here is a substantial limitation in the analysis of race, racism and ethnicity". Meleis (1996: 2) agrees, suggesting that Leininger's theory considers nurses' clients as cultural beings, which reduces the definition of culture to only what is represented by biological and/or psychological beings.

This definition indicates that the provision of care not only depends on nurses' technical experience, but also on their ability to provide service to different types of people regardless of their religion, ethnicity, cultural background or any other issue. The criticisms raised by many researchers have only focussed on the cultural issues related to nurses, while ignoring patients' cultures and traditions. The majority of researchers have not built their argument on empirical studies.

Researchers provide differing reasons for the need and importance of transcultural nursing (i.e. Halligan, 2006; Mattson, 2000). Halligan (2006) emphasises the importance of health-care professionals' understanding of patients' culture while providing care. However, there is little emphasis on the actual benefits of transcultural care. The author merely recommends that nurses are aware of religious and cultural differences when interacting with patients. Ayaz et al. (2010) explored how nurses experience cultural differences between patients in a culturally diverse society. Their study suggests that health needs vary with the cultural background of patients, and so cultural competence is necessary when encountering diversity.

Some researchers recognise that taking account of transcultural aspects in care can actually have an effect on patients' health, and there are theories about how transcultural care can inform nursing practice (i.e. Leininger's theory, Giger and Davidhizar's Transcultural Assessment Model, etc.). Purnell's (2005) findings suggest that it is important for health-care workers to understand that culture is mostly unconscious and has a significant impact on health and illness. Nurses should certainly recognise and integrate this into healthcare. However, Purnell (2005) applies his model of cultural competence to *all* health-care professionals, not just nurses. The author found that culture is a strong influencing factor on both perception of and responses to health care and that culturally competent carers will provide better health care to clients. Becoming culturally competent or 'learning' culture is an on-going process and is achieved mostly through cultural interaction. Kleiman (2006) also recognises that respect for a patient's culture affects the quality of the care and enhances patient outcomes.

Additionally, Aboul-Einen (2002) recognises that the theoretical underpinnings of transcultural nursing have informed practice, and claims that nursing theories such as those offered by Leininger can inform improved patient care. Leininger's (1994) work offers a clear outline of theoretical and practical research into professional health systems, set within the transcultural framework that considers the ethical and moral considerations faced by nurses in transcultural environments. In relation to this aspect, Maier-Lorentz (2008) also acknowledges the benefits of transcultural nursing in informing practice, and emphasises how such practice should meet the cultural and spiritual needs of patients. These needs are also expressed as patient rights, both in terms of the right to have individualised care and the right to be recognised as an individual in a culturally diverse society. Maier-Lorentz (2008) states that understanding cultural needs and differences is important in providing effective care; moreover, she mentions the various aspects that this involves, such as differences in communication and holding different cultural perspectives on health care. However, there is little mention of the health benefits, only acknowledgement of Leininger's connection between culture and care, and health and wellness. A different approach to informing practice was proposed by Kleiman (2006), who proposed that nurses should inquire into an individual patient's personal interpretations instead of relying on a catalogue of cultural attributes. Mebrouk (2008) suggests that the transcultural approach to nursing offers a visionary model that can lead to better nursing practice. A central function of transcultural nursing is cultural assessment, where nurses make an assessment of a cultural group in order to guide their care.

A number of researchers have discussed and provided practical advice on cultural assessment. For instance, Holland and Hogg (2001) felt there was a need to guide nursing practice in terms of providing cultural care. Their approach is regarded as a practical guide that was based on their approach to cultural assessment, specifically relating to theories of transcultural nursing. These theories encompass Purnell's (2005) model of cultural competence, Giger and Davidhizar's (2002) model of transcultural nursing assessment, and Papadopoulos, Tilki and Taylor's model of transcultural skill development (2004). These models are aimed at helping nurses achieve cultural competence and are discussed in the following section.

## **2.6 Cultural Competence**

One of the most fundamental aspects of transcultural nursing is cultural competence. The literature concerning cultural competence in nursing discusses the need to understand culture and the need for cultural competence. It also provides recommendations that can be achieved through a change in attitudes, an increase in understanding and the practical application of skills related to the provision of health care.

Giger and Davidhizar (2002A: 187) define cultural competence as follows: 'A dynamic, fluid, continuous process whereby an individual, system, or health-care agency finds meaningful and useful care delivery strategies based on knowledge of the cultural heritage, beliefs, attitudes, and behaviours of those to whom they render care.' Alternatively, Xu et al. (2005) suggest that cultural competence is reflected in the possession of a high level of cognitive skills, psychomotor skills, and beliefs and attitudes, and in remembering that each person is culturally unique. They propose that having a general basic knowledge of an individual group is a good starting point for providing culturally competent care. These two definitions reflect the different approaches to achieving cultural competence. The former is about developing and delivering health care based on the culture of the patient, whilst the latter is about developing skills and understanding that people are associated with different cultures and needs.

Before addressing the different methods presented in the literature for achieving cultural competence, it is important we acknowledge that there are different reasons provided by

researchers for the need for cultural competence. Most researchers agree that the increased need for culturally competent care is attributable to an increase in cultural diversity amongst both patients and nurses within societies. This may be attributable to an increase in diversity in those societies, which include nurses and patients. Alternatively, it may be the case that, for instance, non-Muslim nurses are employed by Muslim hospitals, allowing them to gain experience in different cultures. This latter reason is related to the present study, which deals with expatriate nurses working in Saudi Arabia. Campinha-Bacote (1999) puts forward a model for achieving cultural competence. The authors attribute the need for cultural competence to a growing multicultural world. However, this is a wide-reaching attribution and fails to specifically acknowledge that diversity and situations where cultural competence is needed can manifest themselves in different ways, i.e. diverse societies with diverse patients and nurses, expatriate nurses working in foreign cultures, or indeed both.

Other researchers (Yarbrough and Klotz, 2007; Xu et al., 2005; Flowers, 2004; Cioffi, 2003) only focus on the situation of a culturally diverse society that has increasing numbers of patients from culturally diverse communities. For example, they discuss societies such as the United States or the United Kingdom where an increase in the number of patients from ethnic minorities means that cultural competence usually refers to nurses working in their own countries and caring for patients from ethnic minorities. Examples of these include Xu et al. (2005), who believe that transcultural nursing originated when demographic changes took place in different parts of the world, such as Western societies in the United States, Europe and Australia, which have become increasingly multicultural. Cioffi (2003) also stresses that Australian nurses often work with people who are from different cultures than their own.

Similarly, Gerrish and Papadopoulos (1999) address the need to overcome discrimination and health disadvantages for ethnic minority communities. In relation to this aspect, Chin (2000) states that the need for culturally competent health care in the US arose out of a need to manage the effects of racism when delivering health care. Therefore, cultural sensitivity was developed in response to the cultural and language barriers encountered by non-English-speaking migrants, and to the prejudice experienced by people of colour. Papadopoulos et al. (2004) argue that diverse populations urgently call for cultural competence in nurses. Yarbrough and Klotz (2007) focus on creating cultural competence in nurses in the US through education, and suggest that the need stems from a dramatic increase in non-dominant ethnic groups in society. Flowers (2004) states that achieving cultural competence is a part of



nursing, and since nursing has always been dynamic it has evolved along with changes in society's expectations, including the acceptance of an increasingly multicultural society.

However, not all researchers in this area focus on the increasing cultural diversity of societies; some of them specifically state that nurses themselves form part of an increasingly diverse workforce. Xu et al. (2005) draw attention to the growing number of Asian and Asian American nurses in nursing education in the United States, and discuss how their education might be facilitated by increasing their understanding of their own cultures. This type of self-awareness is an important part of achieving cultural competence.

There has also been recognition of the need to understand the cultural competence of expatriate nurses working in cultures other than their own, and caring for patients that are part of a more homogenous society. Many expatriate nurses in Saudi Arabia are in this position. The literature in this area typically describes specific situations, for example, expatriate nurses working in Saudi Arabia, and so the resulting recommendations provided for achieving cultural competence are often situation-specific. These works include Van Rooyen et al. (2010), who looked at the experiences of South African nurses working in Saudi Arabia. A phenomenological approach detailed the nurses' experiences, and also revealed the issues and difficulties that arose; based on this, recommendations were provided for the Saudi context. Halligan (2006) also examines the experiences of expatriate nurses caring for Muslim patients in Saudi Arabia; however, the recommendations given here are not specific to the Saudi context. Instead, Halligan recommends that nurses should consider religious and cultural differences when caring for Muslim patients generally. This study is particularly relevant given that Muslims are one of the biggest ethnic minority groups in Britain. There is confusion between wanting to understand the experiences of the expatriate nurses working in Saudi and their own culture.

Hunt (2007) looks at managing equality and cultural diversity amongst overseas nurses (expatriates) working in the United Kingdom, with a view to assessing how they achieve cultural competence. Hunt's study found that overseas nurses, particularly those from the developing world, were discriminated against and had a disproportionate number of complaints made against them. Unlike numerous other writers mentioned in this section, Hunt's (2007) recommendations for achieving cultural competence are aimed not at the nurses themselves, but at those who are responsible for managing them.

The literature above has addressed the wider reasons why there is an increasing need for cultural competence, but some writers also acknowledge that there are benefits in terms of patient care and health outcomes. Jeffreys (2010) considers culturally congruent health care to be a right, not a privilege, and maintains that there is a strong link between culturally congruent care and positive health outcomes. Flowers (2004) argues that cultural competence is also required in order to establish a relationship with patients, which then helps nurses to properly assess and implement nursing and health care.

### **2.6.1 Achieving Cultural Competence**

In order to understand cultural competence in healthcare, it is essential that we grasp an appreciation of the meaning of culture in relation to this concept. According to Giger and Davidhizar (2002A), culture is a behavioural response that has developed from social and religious practices, and is influenced by the norms, beliefs, values and practices of people from the same cultural group. Moreover, the authors propose that culture affects our being, thinking and doing, and forms the expressions of what makes us 'us'. Understanding culture is a very important part of the process of achieving cultural competence, as will be shown in this section. Properly understanding culture requires an acknowledgement and understanding of the similarities and differences between, as well as within, cultures and ethnic groups, and although health-care practitioners often have good intentions in wanting to learn about a culture, they can sometimes ignore the facts and the complexities of culture (Culley and Dyson, 2009). Culley and Dyson (2009) find that appreciating these similarities and differences between and within ethnic groups can help to avoid stereotyping by health-care professionals.

Romanello and Holtgreffe (2009) draw attention to Purnell's model of achieving cultural competence, which is based on the primary and secondary characteristics of culture. Primary characteristics include ethnicity, nationality, colour, age, gender and religious affiliation, and secondary characteristics relate to educational and socio-economic status, occupation, political beliefs and gender issues.

Another model developed by Giger and Davidhizar (2002A) considers communication, space, social organisation, time, environmental control and biological variations as important factors in achieving cultural competence, while Maier-Lorentz (2008) considers communication, touch, space and distance as well as the health-care beliefs of patients. These

writers offer very practical, hands-on considerations, which should be understood and implemented during nursing care.

The recommendations made by these writers are very practical, and there is a simple reason for this: they focus on designing culturally sensitive care, in pursuit of achieving cultural competence, and they emphasise what is most important. For example, the Transcultural Assessment Model presented by Giger and Davidhizar (2002A) provides a framework for designing culturally sensitive patient care. This model is based on the theory that each person is culturally unique and that any assessment should be made against cultural phenomena. Giger and Davidhizar's model includes such practical aspects as physical proximity and social organisation around the family, communication concerns, human interaction, and clashes between cultures. In a transcultural nursing situation, these five points are clearly relevant to this study, i.e. expatriate nurses working in Saudi Arabia, especially in terms of physical proximity, social organisation and communication. This model has been used as a theoretical foundation in a study into cultural competency by Smith (1998, cited in Giger and Davidhizar, 2002A) and in a study by Mullen and Phillips (1998, also cited in Giger and Davidhizar, 2002A) on determining cultural beliefs among Ohio Appalachians in order to provide culturally competent care. The model was used as an overreaching theoretical framework as it is particularly useful in identifying cultural phenomena.

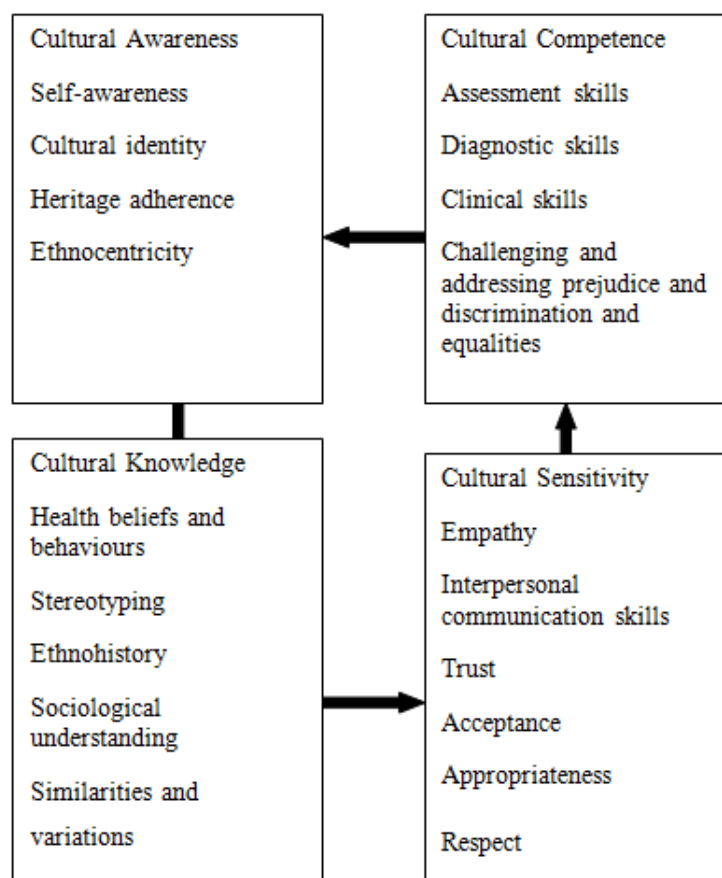
Another approach to achieving cultural competence was put forward by Galanti (2008), who believes it is essential that nurses acquire the skill of critical thinking, as this will allow open questioning and reflective reasoning, leading to care that is both high quality and safe. Further to this, the ability to critically analyse a situation will help nurses to organise and prioritise their workloads.

These models demonstrate a degree of similarity and agreement. The first two stages of each model are almost always the same, i.e. the process begins with self-awareness or cultural awareness, before moving on to increasing cultural knowledge (Campinha-Bacote, 1999; Papadopoulos et al., 1998; Purnell, 2005).

This concept of self-awareness or cultural awareness on the part of those responsible for delivering care was further explored by Purnell (2005). Purnell suggests that the following aspects are important for nurses: being aware of one's own culture; understanding cultures, health needs and the meaning of illness; being non-judgemental; accepting cultural differences; and adapting care. Furthermore, in relation to self-awareness, Gerrish and

Papadopoulos (1999) suggest that any education programme should begin with nurses first understanding their own cultural values and beliefs as well as their prejudices. This notion of self-awareness as underpinning the development of transcultural competence is also illustrated by Papadopoulos et al.(1998) in their model for developing transcultural skills. The model (Figure 2.6 below) contains four main concepts: cultural awareness, cultural knowledge, cultural sensitivity and cultural competence; the process beginning with the sub concept of self-awareness.

**Figure 2.6: The transcultural skills development model**



**Source:** Transcultural care: a guide for health care professionals. *Papadopoulos et al. (1998, p. 179)*

In support of the idea of self-awareness, Maier-Lorentz (2008) agrees that nurses must be aware of personal biases and prejudices. Purnell (2005) elaborates on how this can be achieved, suggesting that nurses must not assume that their beliefs are the same as those of their patients, should resist being judgemental, and should be comfortable and open to cultural encounters. Since different people will perceive similar situations in different ways, it

is important for those involved in transcultural care to first understand their own culture, in order to develop an appreciation of their own beliefs, values and priorities (Jenke and Moffitt, 2006).

However, Wells (2000, p.189) disagrees with the above. The author presents a model for individual and institutional cultural development, stating that 'cultural awareness, cultural sensitivity, and cultural competence do not achieve the level of cultural development necessary to meet the health care needs of a diverse population'. Wells takes a more extended view of cultural competence, and proposes the idea of 'cultural proficiency', which extends cultural competence further than just nursing practice and into areas that include administration, education and research, and which guides individual as well as institutional behaviour. This wider approach was also suggested by Matteliano and Street (2012); found that nurses were able to develop niches in multidisciplinary teams and cultural competence. Purnell (2005) suggests that organisational cultural competence is necessary for both the agencies providing care and those providing health-care education, and Leever (2011) emphasises an organisational approach to cultural competence, based on patients strong cultural identification.

In summary, the literature demonstrates that there is a real need for cultural competence in health facilities such as hospitals and clinics. Studies have focussed on different areas, which mean that they have provided different explanations of the need for, and also the benefits of, cultural competence. The following section explores researchers' views on the importance of transcultural training and education, and the role of organisations in achieving cultural competence.

## **2.7 Transcultural Development and Education**

Several researchers have proposed recommendations for including transcultural aspects in formal education and training. Chin (2000) provides recommended standards for providing culturally appropriate health care, which include the provision of designated staff who are responsible for the implementation of appropriate policies and who will recruit, retain and promote suitably qualified care staff, who are trained to meet the needs of ethnic minorities.

Because cultural care and sensitivity are complex topics, they require a broad holistic approach to teaching, in order to help students to understand and apply the issues in their practice. Introducing transcultural values formally throughout the nursing curriculum should

ensure a move from mere awareness of these values and sensitivity towards them to actual cultural competence (Mixer, 2008). This idea by Mixer reflects the above-mentioned models for achieving cultural competence, such as Papadopoulos et al. (1998), where the learner moves from awareness to sensitivity, and finally to cultural competence.

Whilst the importance of transcultural nursing care appears to have been recognised, much of the literature on how nursing and education have documented their commitment to training and education in transcultural care has been inadequate. One of the main reasons for this has been the lack of commitment from health institutions. Papadopoulos et al. (1998) stress that in order for education and effective change to be manifested successfully in transcultural care, it is necessary to involve the whole organisation. Chin (2000) also approaches the need for cultural competence from an organisational perspective; suggesting that efforts in the past may have been wasted because economic and market incentives are now more of a priority. In fact, much of the literature in this area focuses on improving transcultural education, and is directed towards the organisations responsible. Purnell (2005, p.8) also considers the organisation to be an integral part of cultural competence, with the author writing about 'organisational cultural competence'. The author suggests that all recommendations should be implemented at the organisation level, and that the model for cultural competence should be used to inform education. Gerrish and Papadopoulos (1999), in looking at the challenges that face those responsible for transcultural nursing education, provide recommendations that are clearly intended for educational organisations. These recommendations may include conducting training courses on skills related to provide high quality health care people from different cultures.

Purnell (2005) also draws attention to the importance of cultural competence as part of both the overall mission of an organisation and its orientation and training, and argues for the introduction of mentors for those unfamiliar with their patients' culture.

Despite an acknowledgement of the importance of organisational commitment, researchers have realised that until now, such commitment has been lacking. Mixer (2008) proposes teaching transcultural care as a compulsory component of nursing education to ensure a culturally competent workforce, yet notes that faculties are often not properly prepared to teach nursing students about cultural care and cultural sensitivity. Mixer also laments the fact that despite 50 years of knowledge of transcultural nursing and extensive research, theory and practice, formal education on the topic of culture is still lacking in nursing. Mixer (2008)

suggests that cultural care is a highly complex subject to teach, and identifies both variations between different teaching mediums and the absence of a conceptual framework for teaching care in most faculties.

In fact, literature available from twentieth-century sources does not paint a clear picture of nursing education and the associated curricula in terms of approaches to culture and spirituality; moreover, many studies undertaken in both the UK and the US indicate that the skills and knowledge of nurses in relation to spiritual care have been inadequate (Narayanasamy and Andrews, 2000). Additionally, Maier-Lorentz (2008) and Cioffi (2003) suggest that the majority of qualitative studies centre on the communication difficulties encountered by nurses, which are typically due to deficient training and a lack of education in cultural competence.

Narayanasamy and Andrews (2000) take a completely different approach to other researchers, because in addition to levelling criticisms and providing recommendations for considering spirituality in nursing education, they also say that there is a Christian heritage in nursing education that discourages Muslim nursing students, and that a more multiracial and multicultural composition of students would improve nursing education. This idea is supported by Tilki et al. (1994), who also support the idea of accepting nurses from ethnic minority backgrounds into nursing education.

In order to achieve a high standard of transcultural nursing practice, it is necessary to have a set of standards on which to base evaluation and certification. Some such standards have been developed using a number of relevant theories, including Leininger's Theory of Culture Care Diversity and Universality (Papadopoulos and Omeri, 2008).

Jeffreys and Dogan (2013: p. 88) presented the Cultural Competence Clinical Evaluation Tool (CCCET) as a means to evaluate education programmes that are aimed at achieving cultural competence through, firstly, evaluating the culturally specific care provided to patients of ethnic diversity, and secondly, evaluating the development of the culturally sensitive beliefs, values and attitudes of nursing students. However, the authors go further and propose a more integrated approach to cultural competence education by assessing the culturally specific care provided by students, where cultural assessments are implemented along with an improvement in culturally sensitive attitudes, all through the practical aspects of nursing education.

Researchers have acknowledged that there has been some success in education and training in this field. McDougale et al. (2010, p. 756) explore the success of a programme entitled CARE (Cultural Awareness and Respect through Education), which demonstrated that having undergone cultural training and being experienced in their professional fields, staff receiving cultural competence training were thought to have improved knowledge and skill in this area. However, the staff also acknowledge the importance of implementing this in practice McDougale et al. (2010, p. 756).

Equally, doubts have also been expressed about the effectiveness of education and training. According to Kealey and Protheroe (1996, p. 14), it has been difficult to ascertain whether intercultural training makes any difference to the performance of expatriates working overseas. Kealey and Protheroe attribute this to the fact that much of the literature uses weak methodology in establishing the link between training and effective outcomes. Kealey and Protheroe have used several criteria for testing this relationship, with a focus on longitudinal measures of performance. Furthermore, cross-cultural training is generally often short term and 'one shot', usually lasting for a week or less. Bozionelos (2009) argues that cross-cultural training is not significant for three reasons: it does 'not necessitate substantial cultural competence', cross-cultural training was not found in the relationships studied, and it had no effect on job satisfaction or competence.

More specifically, and in relation to the present study, although it has been mentioned that an understanding of the need for transcultural care is necessary, Bozionelos (2009) states that in Saudi Arabia transcultural training has been found to have no effect at all on the job satisfaction of expatriate nurses, nor does such training create cultural competence. This view contrasts with Leininger's Culture Care Theory, which maintains that nurses require knowledge of different cultures to be able to provide care to people of different ethnicities (Maier-Lorentz, 2008). This is in line with Ruddock and Turner (2007), who found that training advocates on foreign culture bridges the gap between practice and culture. One plausible explanation might be that expatriate nurses in Saudi Arabia are not properly trained. Bozionelos (2009) suggests that expatriates in a managerial capacity in Saudi Arabia are corporate-sponsored and have already had transcultural training, as they are often responsible for setting up operations employing local people. On the other hand, expatriate nurses are non-corporate-sponsored and their work is mostly technical, involving minimal people management, although there is obviously interaction with clients in the host country.



Moreover, Islam has had a significant impact on nursing education. It should be remembered that Islam transcends most races and cultures in the world. Approximately a fifth of the world's population are Muslim, and it is important to consider this in the development of curricula in nursing education, which should incorporate cultural and spiritual dimensions when caring for Muslim patients (Narayanasamy and Andrews, 2000).

## **2.8 Religion and Spirituality**

The relationship between religion, spirituality and health care is complex, and different authors have differing viewpoints on this. Bursey (2009) recognises that there has always been a relationship between religion and healthcare, since all religions offer an explanation for illness, principles for the treatment of illness and concern for the maintenance of health.

Narayanasamy and Andrews (2000) approach the issue of religion and spirituality by first addressing what spirituality is, before suggesting that it becomes more focussed for a person when they face illness or death. As an example, the authors also propose that for Muslims their religion provides a source of comfort during ill health.

More specifically, Ross (1994) cites Renetzky (1978), who provides a more comprehensive definition of the relationship between religion and spirituality in terms of three components: the meaning, purpose and fulfilment of life, suffering and death; the hope/will to live; and belief and faith in the self, others and God (p.439). This point is also emphasised again by Ross (1995, p.457), who says that this interpretation of spiritual meaning is important for achieving health, also referred to as a person's 'health potential'.

A different viewpoint is offered by Henley and Schott (1999), who suggest that a patient's religion or spirituality affects how they perceive and react to their condition: for example, pain is found to be significantly affected by religion. They find that although most religious people would agree that pain should be removed or at least controlled, some religions argue that it is necessary to accept pain without complaint, and some believe that pain allows them to atone for past sins – a point agreed with by Boyle and Lee (2008).

Despite the different viewpoints on why religion and spirituality are important, there is a consensus that it is important to fulfil a patient's spiritual needs in health care. Pesut et al. (2008) believe that religion and spirituality have to be conceptualised in relation to health

care so that the diversity of society is represented, and Holland and Hogg (2001) propose that in order to fulfil a patient's spiritual needs it is important for the carer to understand the basics of a religion. Maier-Lorentz (2008) suggests that it is important that nurses are educated about religious beliefs and are trained to manage them appropriately.

Johnson (2001) researched perspectives on religion in the NHS, and found understanding of religion was a useful tool for understanding culture in a multi-faith society. He suggests that it is important for those in positions of responsibility to make sure that carers maintain an awareness of culture, traditions, language and beliefs. Johnson (2001) draws attention to the Patient's Charter of 1991, which states that patients should be afforded mutual respect in an environment that is supportive of their privacy and religious perspectives.

However, there is concern that patients' spiritual needs are not being met (Narayanasamy and Andrews, 2000; Gatrad and Sheikh, 2001; Ross, 1997). Gatrad and Sheikh (2001) approach the subject from a very practical point of view as they examine medical ethics and Islam within the UK. They argue that the NHS is not succeeding in providing for the needs of minority ethnic groups, most specifically in relation to issues such as blood transfusions, contraception, abortion and organ transplant, which are all weighty topics that are very much embedded in religious and cultural beliefs. Alternatively, from a more spiritual perspective, Ross (1997) claims that there are insufficient guidelines for nurses seeking to provide spiritual care, and Ross goes on to propose a conceptual framework to fill this gap. The framework comprises firstly, assessment of spiritual needs or spiritual distress, followed by planning intervention to determine appropriate care to meet those spiritual needs, and finally, an evaluation to establish indicators of spiritual well-being.

The literature also tackles the issue of religion in relation to culture, which is relevant to the present study. Much of the literature on transcultural nursing care and cross-cultural competence is focussed on the culture of the patient, and religion and spirituality are often seen as a component of the person's overall culture. Bursey (2009) explains that although culture is the 'totality of the customs and practices of a distinct group', religion is an aspect of culture, and it can be difficult to separate the two; this is particularly the case with a religion such as Islam, where the practice varies from one culture to another. This idea is supported by Henley and Schott (1999), who state that there are differences in the perspectives and lifestyles of people from different cultures who share the same religion. An additional point

that could be concluded from this is that it is possible for people of the same religion to have different cultural needs.

Of particular relevance to this study is the idea that Western notions of religion, which are interpreted within a context of individuality, are very different from those of Islam, which views religion as a complete way of life and for most adherents is tied into with spiritual aspects. Moreover, Pesut et al. (2008) claim that conceptualisations of religion and spirituality in the West have reduced the authority of religion. Importantly, in recent years postmodern spirituality, which places an emphasis on the individual spiritual experience (Henley and Schott, 1999), has risen in popularity.

## **2.9 Islam and Health Care**

The Muslim population is spread across all countries around the world, with the majority living in countries such as Saudi Arabia, Indonesia, Turkey and Iran, in many other parts of Asia and in Africa. Muslims come from diverse backgrounds in terms of their ethnicity, language, culture, education and social class, and have different ways of expressing their religion (Pennachio, 2005). With approximately 1.2 billion followers, Islam is the second largest religion in the world. This diversity in understanding and expression of Islam highlights the need to study individual groups of Muslims rather than treating Muslims as a generic group when it comes to transcultural health care. The fundamental tenet of faith is the ‘shahadha’, the declaration that there is only one God, in Arabic ‘Allah’, and that Muhammad is the messenger of God. Like other religions, Islam is interpreted in numerous ways; those who practise pray five times a day facing Mecca by reciting parts of the Quran and other supplications, while performing the physical actions of standing, bowing and kneeling. Each prayer lasts for approximately five minutes (Narayanasamy and Andrews, 2000). The Prophet Muhammad introduced Islam in the seventh century, and, according to the faith, was the last prophet of God who was chosen to deliver, interpret and teach the Quran. The Quran is written in Arabic and is the foundation for Islamic law (McKennis, 1999). There are five main pillars of faith in Islam, which are as follows:

Shahadah: The declaration of belief, which is spoken many times a day: ‘There is no God but Allah and Muhammad is his messenger.’

Salat: The five compulsory daily prayers.

Sawm: Compulsory fasting during daylight hours in the month of Ramadan, depending on a person's health.

Zakat: Obligatory charity.

Hajj: The holy pilgrimage to Mecca, which should be performed at least once in a person's lifetime if the person is able to do so (Narayanasamy and Andrews, 2000).

Of the above pillars, praying and fasting are most relevant to this study because they are physical features that must be considered by nurses caring for Muslim patients.

For Muslims, guidance is derived from the Holy Quran and the Sunnah (sayings and actions of the Prophet Muhammad (PBUH)). Islam provides its followers with guidance on personal, social, moral, political and spiritual matters, both for individuals and for society. Islamic teachings on health are important for nurses, carers and the population as a whole, as the Quran instructs Muslims to protect their health and make every effort to maintain a clean and healthy environment. Health is viewed as a blessing from Allah and illness is a way in which one can remove sin and earn greater reward in the hereafter. This idea is supported by al-Shahri (2002), who said that Muslims believe in the predestination of man and that any illness is the will of Allah; they view it as expiation of sins rather than a punishment.

It is important in the present study to understand the role that religion, in this case Islam, plays in the health care of patients. The literature shows that Islam has an influence on care in a number of different ways and that caring is not a new concept to Islam, as Johnson (2001) draws attention to the fact that Muslims are obligated by Islam to care for the ill, the infirm and the elderly.

Some researchers discuss how Islam provides answers to why people become ill and the predestination of man (al-Shahri, 2002) and how Islam prescribes both preventative and curative medicine (Boyle and Lee, 2008; al-Shahri, 2002). Other writers focus on the spiritual aspects of care and well-being (Pesut et al., 2008) and on the practicalities of caring for Muslim patients by taking religious practices into consideration (Holland and Hogg, 2001; Mavani, 2010). Finally, scholars such as Dhami and Sheikh (2000) focus on the family unit in Islam and its importance in health care.

The existence of illness is accepted by Islam, and Muslims believe that Allah has the power to cure. Traditional healers invoke spiritual healing by reciting from the Holy Quran; this is a

well-accepted practice. It is important that nurses caring for Muslim patients base their practices on such Islamic values (Boggatz et al., 2009). Spiritual healing is found in Saudi Arabia as well as in the rest of the Muslim world. According to al-Shahri (2002), the most common spiritual healing practices for Saudis are those related to the Quran and the teachings of the Prophet Muhammad, and these include abandoning the effects of jealousy, the removal of jinns and the recitation of Quranic verses.

Writers such as Johnson (2001) have explored spirituality in health care and have investigated the roles of non-nursing staff such as chaplains, although they have been perceived as occupying a separate dimension of care within hospitals. In Saudi Arabia, where Islam is the main religion and is very much tied to cultural parameters, faith is something that will be a feature of all patients in hospital. Therefore, international nursing staff from varied ethnic, religious and cultural backgrounds should be aware that Islam plays an integral role for these patients. This is described by Ross (1994), who considers spiritual care to be part of the nursing role, and as such, spirituality should not be considered as a separate but rather an integral part of an individual. As previously mentioned, the spiritual side of humans is more evident in times of emotional stress such as an illness or death.

The present study is based on the notion that an understanding of the significance of spirituality in Islam is essential in working with Muslim patients. For example, the heart may have a different meaning in Western pluralist culture than in cultures in the Middle East. Thus, in Islam, heart disease may not be considered a physical illness but one requiring spiritual care to remove afflictions such as malice, hatred or envy (al-Shahri, 2002).

These spiritual and religious aspects have an impact on the experiences of nurses. Halligan (2006) finds that such sentiments make nurses feel helpless in the face of patients' attitudes. Another relationship between religion and providing care is presented by Mebrouk (2008), who asserts that a nurse's religious convictions significantly affect the way they act in the workplace; this is in opposition to the Western secular concept of religion as being very much an internal and personal matter.

According to Boyle and Lee (2008), there are some differences of opinion about medication, ranging from the clear prophetic saying that for every disease God has provided a cure, to the belief that medication is permissible but that avoiding it is preferable, which was mentioned by one of the four Imams, Sheikh Ibn Hanbal. Nonetheless, Muslims in Saudi Arabia still seek medical cures or preventative medicines for illness. According to al-Shahri (2002),

traditional medicines and traditional practices are still used in the country and techniques include cauterising, cupping and traditional herbal medicines, Zam Zam water (holy water), honey and black seeds (Nigella seeds) (al-Shahri, 2002). Al-Shahri (2002) also suggests that traditional medical practitioners may be illiterate and demand that a patient stop taking conventional medicine. This could help to explain patient behaviour and attitudes towards conventional nursing care. However, contrary to this idea is the notion that Arabs have a high regard for Western conventional medicine (Walczyk, 2006). In terms of diet and nutrition, foods that are commonly preferred are those identified in the Quran and Sunnah, such as honey, dates, olives and olive oil, figs, raisins and black seeds (black cumin). There are practical considerations surrounding medicine suitable for Muslims; only certain types are deemed permissible. Of particular concern are capsules made from non-halal gelatine or medicines that contain porcine derivatives. It is also necessary to consider whether the timing of administration interferes with fasting during Ramadan, although most religions, including Islam, do not require fasting during illness (Henley and Schott, 1999; Mavani, 2010). In relation to the practical aspects it would be important for expatriate nurses in Saudi Arabia to understand that there are a number of cultural and religious influences that must be considered in reference to the health of Saudis. Alcohol is considered an illicit drug and is completely forbidden, and smuggling alcohol can result in the death penalty. Smoking is common among Saudi males, there is a lack of physical exercise, and sexual contact outside of marriage is not allowed. These factors not only affect the health of Saudis but also their healthcare. For example, it would be insulting to ask a female patient about their smoking history (al-Shahri, 2002). Cleanliness is an important part of everyday Saudi life: before performing prayers the person should be clean: there should not be any blood, urine or faeces on any part of the clothes or body, and a spiritual cleansing must take place (al-Shahri, 2002).

The family structure also exerts an influence on caring in the Islamic culture. In most Islamic countries the family is the strongest social unit, and it is considered the foundation of a healthy and balanced society (Dhami and Sheikh, 2000). Structurally, the Muslim family is an extended one, and a person identifies himself or herself with the tribal entity. This structure aims to offer stability, coherence and physical and psychological support, particularly in times of need. Age also plays an important role in the structure of the Islamic family and this is associated with wisdom and life experience, so that older family members have high status, deserve respect and have the power to make major decisions about family issues. Regarding motherhood, in Islam, as in other religions such as Christianity and

Judaism, it is forbidden for unmarried women to conceive. As a consequence, women find themselves living within family boundaries that are ruled by religious and cultural values.

In terms of the practical aspects of providing healthcare, one of the main issues relating to healthcare and Islam is gender and modesty. The issue of gender is crucial to Islamic culture and therefore should be considered in nursing care. Upholding one's modesty is obligatory in Islam and it is preferable for a Muslim patient to be examined by practitioners of the same sex (Holland and Hogg, 2001). Although in many Arab Muslim countries, female nurses provide nursing care for both male and female patients, this is not accepted in strictly Islamic countries, such as Saudi Arabia, where men and women have separate lives and inhabit separate social circles (al-Shahri, 2002).

In relation to gender, research demonstrates differing attitudes amongst patients towards nurses. Halligan (2006) identified problems with elderly Muslim male patients who did not want to be cared for by female nurses, and the same was true for female patients and male nurses. This was especially a problem in cases of critical care situations, where patients had to be lifted by two members of staff, which may have included a male staff member. Moreover, the issue of sexual morality has an influence on a number of health-care-related issues, such as birth control, abortion and reproductive technologies (Mavani, 2010).

In addition to the spiritual aspects addressed above, practical matters must be considered, such as the need for prayer and washing or ablution (for example, Muslims need to wash after urination or defecation before they can pray) (Holland and Hogg, 2001). Ritual washing is particularly important at the time of death, and at this time health-care providers must understand and be sensitive to the need for specific rituals, such as the washing and preparation of the body.

Mavani (2010) makes a number of recommendations for health-care providers taking care of Muslim patients that comprehensively cover all the issues raised above. This includes asking the patient whether they would like privacy to pray, if they require their carer to be of a specific gender and if they would like an imam. Mavani (2010) also warns against assuming that religion is not a major concern for patients and that prayer is unimportant while they are in hospital. Prayers are central to the lives of Muslims and according to Boyle and Lee (2008), they provide patients with essential spiritual support during times of illness.

In conclusion, this study is primarily concerned with religion as a factor in the experience of nurses; however, in examining this relationship it is not possible, and indeed not wise, to isolate religion from other aspects, since non-Muslim nurses' experiences will be affected by other factors, especially cultural factors. All these factors are integrated and related to each other, something that is fully considered by Purnell's model, which would, for instance, recognise that prayer, as an aspect of the domain of spirituality, is related to and affects rehabilitation, which in turn is part of the health-care practice domain. Therefore, Purnell's model reflects real-life situations where a non-Muslim nurse caring for a Muslim patient may experience some or all of the domains in one interaction.

## **2.10 Nursing in Saudi Arabia**

Much of the literature on nursing in the Islamic faith pertains to the early Islamic period in the Arabian Peninsula, which nowadays is known as Saudi Arabia. The following section will consider this literature.

Arab women in the early Islamic period were knowledgeable in the fields of first aid and nursing care, and cared for patients in times of war and peace. At that time the Arabs referred to them as the 'Alaseyat' or 'Alawasy', meaning those who empathise with patients. Aisha Bint Abubaker, the Prophet Mohammad's (PBUH) wife, was known as the 'Mother of the Believers' and was a pioneer of nursing care among Muslim women by means of her work in nursing patients in the battlefield; she also nursed the Prophet Mohammad (PBUH) during illness.

Jan (1996) writes about Rufaidah bint Sa'ad, recognised as the first Muslim nurse and the founder of nursing in the Islamic world. She was born in Yathrib (Madinah) before the arrival of the Prophet Mohammad (PBUH) in the city in the eighth century, and was among the first to embrace Islam. She welcomed the Prophet (PBUH) on His arrival in the city. She learned medical care from her father who was a physician, and later established a field hospital and managed volunteer nurses who helped in treating those injured during battle. Besides nursing the injured, she also adopted the role of a public health nurse and also a social worker, where she helped those with social problems and the poor and needy, and for this she was presented with a medallion by the Prophet (PBUH).

Nursing by Arab-Muslim women continued beyond the Arabian Peninsula to places such as Baghdad and Alndalus (southern Spain). These women were known for splinting broken



bones and providing spiritual care for terminally ill patients, along with performing midwifery duties. The following is an overview of important features of nursing in the Arab world:

- Nursing was an accepted profession in the Islamic world.
- Women could volunteer to join the military service to nurse wounded soldiers.
- The Prophet Mohammed (PBUH) rewarded women who nursed during the war with a part of the war booty similar to that given to the soldiers.
- Nurses were assigned according to their competence and experience to lead and care.
- Practising nurses were women who had a good reputation and high position in society.

Saudi Arabia has a population of over 20 million, with approximately six million expatriates. The kingdom is a recognised force in global political and economic spheres. Because of its economic success, the government has built many well-equipped hospitals and provided a great deal of employment in the health-care sector. According to Tumulty (2001), the nursing profession started to develop in the 1950s, when it was based on private and military models. The health-care system in the country is divided into 18 regional Amaraahs, which are headed by regional directors. During the 1980s the government commissioned a large-scale construction of hospitals, and by the late 1990s there were 314 hospitals staffed with more than 32,000 doctors and 65,000 nurses. However, most of these medical staff were expatriates (Aboul Enein, 2002). Tumulty (2001) says that formal training for nurses began in Riyadh during the late 1950s, and since that time there has been a significant increase in people admitted into hospitals, because of population growth and an increase in the elderly population.

Aboul Enein (2002) mentions that there is a high dependency on expatriate nurses from countries such as the USA, England, Canada and Australia in Saudi Arabia, and that nursing in Saudi Arabia is characterised by high salaries as part of a government initiative to attract foreign nurses. Tumulty (2001) offers an explanation for the high dependence on expatriate nurses; Tumulty stresses that there has been a low intake into the nursing profession by Saudi nationals because of, firstly, the perception that it is ‘an unacceptable profession for Saudi nationals’, secondly, strict admission criteria, and thirdly, the relatively long duration of the

training course, which is five years compared to six years for medical training. However, there may also be deeper reasons for the low intake. Mebrouk (2008) discovered that Saudi nurses often mentioned Saudi society's disapproval of nursing for women, which mainly relates to gender segregation issues. There is further evidence that the role of women in Saudi Arabia is frowned upon in Halligan's (2006) study of expatriate nurses caring for Muslim patients in Saudi Arabia: here Saudi male patients did not like being cared for by female nurses. A significant finding in Van Rooyen et al.'s (2010) study was a feeling of gender discrimination and segregation; however, one criticism of Van Rooyen et al. (2010) is that the study related to the entire experience of expatriate nurses, including life in Saudi Arabia generally, and failed to probe more deeply into the gender issues in relation to caring for Muslim patients in Saudi Arabia.

Al-Shahri (2002) aims to improve awareness of cultural issues in healthcare in Saudi Arabia. He states that Saudis are a subcultural group, and thus a number of factors aside from religion can influence their culture; these include education, economic situation and environmental factors. However, he does recognise that even in the Saudi context Islam is the main influence on culture.

As evidenced above, Saudi Arabia could be considered unique, and this should be considered in relation to expatriate nurses working in the country. Relating to this, Luna (1998) provides some general guidelines for those designing education programmes to teach non-Saudi care providers how to provide culturally congruent care to Saudis; she states that 'the Kingdom is a unique model of unity within the context of the Arab world' (Luna, 1998, p. 9). This assessment is supported by al-Shahri (2002), who states that although Saudis do have a lot in common with Muslims and Arabs around the world, Saudi culture is unique in many ways.

Al-Shahri (2002) also advises against pursuing an evaluative or judgmental approach, arguing that it is better to increase awareness and understanding when studying the culture of a particular group. The uniqueness of Saudi has implications for the provision of culturally competent care, because according to Chin (2000), cultural competence is central to any organisation that cares for an ethnic-specific group, the goal being to make the wider system more responsive to the needs of the target population. This is in contrast with mainstream organisations which have to target all groups in order to provide culturally competent care.

In contrast with the above idea that there is a need for improved training and development of nurses through better understanding of Saudi culture, Aldossary et al. (2008) suggest that the

solution to providing more culturally appropriate holistic care lies in increasing the number of indigenous people in nursing. The authors explain that the main reason for this is that there is a need for a shared culture and language. Unfortunately, although Aldossary et al. (2008) do address the issue of expatriate nurses and inadequate cultural competence, they do not offer a solution to the current problem, i.e. how to train expatriate nurses in the Kingdom properly.

Aldossary et al.'s (2008) ideas are supported by a study by Mebrouk (2008), who found that Saudi nurses perceive Islamic values to be important in caring for Saudi patients. More specifically, their Islamic belief was used in their nursing care based on the teachings of the Quran and the Sunnah (life of the Prophet Muhammad (PBUH)), and their language was considered important in positively affecting the patients' satisfaction and outcomes (Mebrouk, 2008).

## **2.11 Gender Issues**

This study addresses the experience of non-Muslim nurses, who are predominately female, caring for Muslim patients in Saudi Arabia. As such, it is necessary to understand the issues that are related to gender in a male-dominated society, while women are expected to fulfil certain roles such as domestic chores at home including bringing up children.

Women do not have an active role in the workplace in Saudi Arabia. Al Munajjed (2010) takes a holistic view on why this might be the case. The author does not only focus on religion and culture, which are often blamed for a lack of women's participation; rather, she provides a wide-ranging and practical picture of legislative, educational and occupational issues, among others, as well as the social constraints on women that prevent them from entering the workplace. Munajjed (2010) sees the lack of women in the workplace as an untapped resource, and blames the issue of dependency on expatriate workers on this problem. However, this is not to say that the issue of culture and the role of the family is not the most pressing issue, because the author suggests that even labour market reforms should include legislation to promote gender equality and family-friendly mechanisms. Unfortunately, it is not just the workplace arena where women are restricted. Al Heiz (2011) appreciates the step towards allowing women to participate in the Majlis Ash Shura council (Saudi Parliament) but suggests that this is not enough and offers no meaningful solution. ; Al Heiz (2011) also draws attention to the fact that most graduates in the Kingdom are women and that more women receive state scholarships for education than men. While Al Heiz seems to address the issue of women's participation from the perspective of political reform,

in reality she expresses that such efforts are a mere token, and that the real reason for women's problems in this sense is the opposition by the religious establishment, which has had the power to deter labour ministry decisions. Thus, overall there is a deviation between the religious establishments and political decision making (Al Heiz, 2011), suggesting that the reason for women's non-participation may lie with religion. The same issue of women's exclusion is also addressed by Hamdan (2005); however, here both socio-economic and political factors are blamed. Moreover, although Al Heiz (2011) mentioned women's education as a justification for more participation, Hamdan (2005), while recognising the high level of women's education, suggests that women's education is not currently used as a tool for social change but as a tool for conservation. By this, he means that women are restricted in what they can study, and therefore education further entrenches the gender roles enforced by socio-economic and political factors.

The above viewpoint could be considered to be cynical. Alsaleh (2013) highlighted that for a long time Western scholars have suggested that women in Saudi Arabia have faced inequality, and have blamed Islam for this. Alsaleh (2013) disagrees, inferring that such views are pessimistic. Alsaleh (2013) uses a definition of gender inequality to prove her point, and suggests that such inequality is about the roles of women and men being differently valued. She proposes that laws, policies and society as a whole should be accessible to all and that the aspirations of women should be considered equal to those of men. However, although this is a valid argument, it still does not address the wider issue of women's participation in the workplace. Al Mohamed (2009) counters the idea that women have different roles, suggesting that despite the fact that women are considered to be important in Saudi Arabia, women's rights are still an issue. Here, as with the writers above, the problems are not blamed entirely on religion and culture; Al Mohamed (2009) instead highlights a wide range of issues, which include political and legal aspects as well as culture, in the form of restrictions imposed by legal guardians. The aforementioned gender issues are also relevant to the role of nurses in Saudi Arabia.

## **2.12 Social Aspects Related to Provision of Health Care**

This section discusses different social aspects relating to the provision of health care, such as family interference and respect shown to patients and nurses.

### **2.12.1 Family Interference**

Several studies have documented family members' interference in patients' decision making, diagnoses and the provision of signatures (i.e. Bauman et al., 2003; Arnold et al., 2010; Poss, 1999). For instance, Bauman et al. (2003) stress that family members' involvement in different issues relating to patients, such as their diagnosis and medication, affect the health care provided, breaking the ethical issues relating to confidentiality and privacy of information. According to Arnold et al. (2010), family members are conventionally recognised as surrogate decision makers because they are pressured to know the patient's preferences and to act in the patient's best interest. In general, Arab and Muslim cultures are characterised by a family system, the role of individuals within the social organisation (i.e. family), and gender roles. Nurses from non-Arab and non-Muslim countries are not accustomed to or familiar with such cultures. For instance, Western culture focuses on individuals rather than on groups (Hofstede, 2000). Family members influence patients' decisions not only in Saudi Arabia and developing countries, but everywhere, including in developed countries. For instance, a study conducted by Poss (1999) on Canadian hospitals found that patients' decisions regarding diagnosis and/or medication were heavily influenced and/or made by family members. The study demonstrated that nurses were opposed to this type of interference because they felt that patients alone should be responsible for providing their consent.

In Saudi Arabia, family members, relatives and friends are a constant presence in the patient's room. Therefore, communication from health-care providers (i.e. nurses, physicians) does not take place directly with patients but with family members (Van Rooyen, 2008). According to Van Rooyen (2010), the presence of family members and friends in the patient's room hinders verbal and non-verbal communication with patients. Non-verbal communication, according to Ross and Deverell (2004, p. 29) relates to communication using body movements or facial expressions.

Halligan (2006, p.1568) indicated that families in Saudi Arabia often ‘dictated the care’ and controlled the extent of the care, often without the patient’s knowledge, and that this was a cause of stress to the nurses. According to al-Shahri (2002), Saudi culture dictates that the family decide how much to tell the patient. The nurses in this study were surprised at the level of involvement, influence and interference by patients’ families, and that these family members were allowed to have an impact on patient care. It was also noted in a study by Halligan (2006) that the role of the family played a significant part in the experiences of expatriate nurses in hospitals in Saudi Arabia, and that these families were an impediment to meeting the patients’ needs. Furthermore, Van Rooyen et al. (2010) reported that expatriate nurses working in Saudi Arabia found it difficult to adhere to a routine and perform their duties, because the patients’ families controlled when these duties should be carried out. Sidumo et al. (2010) also reported that 70 percent of non-Muslim nurses in their study found family involvement in the management of the patient to be a challenge.

Leininger (1981) stressed that the inclusion of a patient’s family in the planning of care is essential to the delivery of culturally competent care. An empirical study conducted by Hammond et al. (2005) on the Arab communities in the United States emphasised that Arab and Muslim families have an important role in treating patients’ illnesses. Family involvement in health care has long been regarded as a pivotal and significant contributor to the socio-psychological well-being of patients. Families have been seen in some cases as the principle decision makers in relation to health care. Doctors and nurses mainly discuss major diagnoses and ethical decisions with family members rather than with patients.

### **2.12.2 Respect and the Role of Nurses**

Browne (1997) writes that the term ‘respect’ is critical in nursing. However, respect may have different meanings to different individuals depending on culture or age. Respect can be an abstract term, such as appreciation or recognition or a deed of esteem. Burkhardt and Nathaniel (1998) document respect from the point of view of ethical and nursing principles, stating that respect is the core of added value to caring for people. Professional nurses should realise that providing care to people should be unique and should not harm and abuse patients.

Several studies have been conducted on respect. For instance, MORI (2002) conducted a survey on internationally recruited nurses which demonstrated that carers and patients’ family members did not respect the nurses and often tried to avoid them. The survey also found that

family members usually reported problems directly to the manager rather than to the nurses. A survey on senior nursing officers conducted by the National Organisation of Nursing Executives (2003) found that these officers also faced a lack of respect from patients. This affected their ability to innovate and develop new methods to improve patient care. On the other hand, studies have also shown that patients can often be disturbed (in terms of not being allowed to have peace) and not respected by nurses. For instance, Sawada et al. (1996) conducted a study in Brazil which emphasised a lack of respect for patients from nurses; this was illustrated by nurses making noise and turning lights on while the patients were sleeping. Sawada and her colleagues indicated that nurses in this study did not respect the personal and territorial space of hospitalised patients. In relation to this, Slettebo (2008) found that the nurses in this study did not give sufficient attention to patients, leading to the patients feeling they were not respected, which then gave them a feeling of insecurity. These actions from nurses led to such patient consequences as negative feelings, decreased quality of assistance and negative changes in their sleep patterns.

In another study conducted by Dickerson (2009) in the United States, the author argues that the mutual respect between nurses and patients, as well as family members, contributes to the development of the health-care system in hospitals and clinics. In parts of the world such as Egypt, nurses are usually female, and they have been looked upon as being unintelligent because they are women. Nurses are not respected since they are often viewed as 'errand girls' by doctors, who are mostly male. The literature in this area documents that nursing is very different all over the world, and each nation has its cultural and political perspectives which influences the practise of nursing. Additionally, nurses are viewed differently by lay people and professionals (Gray, 1992). For instance, doctors and nurses communicate on a daily basis regarding the health care provided to patients. Despite this communication between parties in hospitals, doctors and nurses have different perceptions of their roles and different duties, leading to them having different goals for patients (Gjerberg and Kjolsrod, 2001). According to Gray (1992), there are some gender issues in how doctors communicate with nurses in workplace situations. In general, most doctors are male and most nurses are female, so communication problems may arise due to gender differences, and thereby nurses may find themselves being disrespected and not appreciated. From an organisational communication literature perspective, 'hierarchies present a communication and collaboration barrier' communication and collaboration barrier is the hierarchies (Danserea and Markham, 1987). In general, health-care institutions are characterised by a hierarchical

culture where doctors are at the top while nurses are in a low position. Despite this hierarchy, interaction and collaboration between doctors and nurses should be positive and help to ensure that proper care and treatment are provided to patients (Weick, 2002). Weick (2002) suggests that when hierarchy differences exist, some people, i.e. nurses at the lower end of the hierarchy, are uncomfortable about expressing their views and talking about problems such as the heavy workload on their burdens and treatment by doctors. In contrast, Gjerberg and Kjolsrod (2001) found that nurses treated female doctors with less respect than male doctors. This is closely linked with female doctors' experience of receiving less help and assistance than their male colleagues. It could be suggested that there is no reason to believe that gender divisions are less important in hospitals than in the rest of society. Interaction between hospital staff and patients also involves negotiating gender, and the effectiveness of this will probably influence the patients' experience of their hospital stay (Annendale and Hunt, 2000). This literature review indicates the existence of gender stereotyping both in medical care in general and nursing care in particular (i.e. Wallen et al., 1979; Hosoda and Stone, 2000).

### **2.13 Intercultural Communication and Language**

Language is a crucial aspect of the care relationship between patients and health-care providers (i.e. nurses, doctors). According to Purnell et al. (2011), language difficulties are the most significant barrier to providing high-quality health care, and thus language constitutes an important component of cultural competence in nursing.

As a result of globalisation, countries are becoming increasingly multicultural and people of different religions, cultures, ethnicities and languages are meeting and living in the same locations, requiring nursing practitioners to engage in effective transcultural practice (Holland and Hogg, 2001).

Researchers commenting on language barriers in health care frequently express concern about the issue of misdiagnosis. Holland and Hogg (2001) state that inadequate or inappropriate care may be provided if attention is not paid to language and communication needs, and health-care decisions based on inadequate information could in some cases be incorrect. Anderson et al. (2003) also argue that language barriers can lead to errors in diagnosis and consequently inappropriate care.



From a holistic point of view, Holland and Hogg (2001) suggest it is important for people to be able to express themselves clearly, and this is necessary to enable us to discuss basic human needs, as well as being a requirement of social fulfilment in care. Furthermore, Henley and Schott (1999) consider that illness itself causes confusion, anxiety and pain, which can in some cases permanently or temporarily inhibit a patient's ability to speak or understand a second language. Chin (2000) recommends providing clients who have limited English language capabilities with interpreters or bilingual staff, translated signage and educational material, and proposes that clients' communication needs be included in the organisation's management system.

Communication skills are also very important when caring for patients, especially in the case of individuals from another culture. The most significant issue in relation to intercultural communication is the language barrier, although it is also necessary to understand a person's culture for communication to be effective (Holland and Hogg, 2001). Specifically in relation to the language barrier, patients may not be able to ask for help or voice their concerns; thus there may be an increase in fear and a feeling of helplessness if they feel that they have been prescribed the wrong medical treatment (Henley and Schott, 1999).

Jacobs et al. (2004) draw attention to the role of the institution in providing interpreter services and suggest that because institutions provide inadequate interpreter services, or none at all, patients are not receiving the quality of health care they need. Overcoming language barriers depends to some extent on the perception of the costs or benefits of interpreter services. Jacobs et al. (2004) argue that although many health-care institutions do not allow for interpreter services because of the financial burden this seemingly imposes, such a measure is a mistake. These institutions, they believe, do not realise the costs of failing to provide proper services, or the cost benefits of improved communication with patients. Their study concludes that offering interpreting services to patients is a financially viable way of providing enhanced health care to patients with language difficulties.

## **2.14Summary**

In conclusion, this chapter has reviewed the relevant literature in relation to the aims and objectives of this study. The review began with an overview of the literature relating to care and caring, before moving on to transcultural nursing and culturally competent care. This was then followed by an exploration of how objectives were achieved through the development of culture competence and education. In line with the central topic of this study, the review then surveyed the areas of religion and spirituality, with particular attention being paid to Islam in relation to health care and nursing. Finally, a focus on nursing in the area under investigation, Saudi Arabia, considered issues related to the presence of expatriate nurses. The following chapter presents the chosen methodological approach of this study and the methods employed.

It is clear that the literature documents many different ideas and approaches to cultural competence and religion. Moreover, the recommendations that have been made, in terms of how to achieve cultural competence specifically in nurses, although being very useful, do not consider individual contexts, e.g. Muslim patients in Saudi Arabia. The literature shows that there is a lack of empirical studies relating to transcultural nursing, particularly in the context of Saudi Arabia. Those studies conducted in Saudi Arabia and even at an international level are general, and do not address in-depth practical aspects of religion such as prayers, fasting and spirituality.

The literature also shows that patient safety is affected by nurses feeling overloaded with work, and by a lack of communication between nurses and patients. Moreover, it appears that the respect shown to nurses depends upon the relationship between nurses and patients as well as that with family members and relatives.

## **CHAPTER THREE: Research Design and Methodology**

### **3.1 Introduction**

Chapters One and Two of this thesis presented the background to the study, the research questions and related literature, enabling the researcher to refine the research questions and synthesise literature related to the research questions. The research objectives are mainly conceived with respect to the research design and the methods used. The present chapter will present and discuss a range of research paradigms and methods, with a particular focus on the phenomenological approach, the predominant methodology of this study. The uniqueness of this study stems from its ability to benefit from the literature review and from previous empirical studies, which utilise a range of research methods such as phenomenology, ethnography and grounded theory. The nature of scholarly study requires the use of various research methods, to confirm the method that is best able to answer the research questions.

The present chapter will consist of twelve sections, as well the introduction. The second section will remind the reader of the study questions. The third section will focus on the research philosophy, including epistemology, ontology, methodology, positivism and interpretivism. The fourth section will discuss the quantitative and qualitative research methods, and the fifth section will present and justify the choice of research methodology for this study with a focus on the differences between grounded theory, ethnography and phenomenology. The sixth section will present the sampling strategy with a particular focus on the sample size of nurses and patients, as well as the sampling method. The seventh section will discuss instrumentation and the design of the interview schedule for focus groups and interviews. The eighth section will summarise the focus group data collection method, while section nine will focus on the interview based data collection. Section ten will present and discuss the data analysis strategy, and section eleven will weigh up the trustworthiness of qualitative data compared to quantitative data. Section twelve will provide information about the ethical framework used in the study, and, finally, section thirteen will conclude the chapter.

### **3.2 Addressing the Study Objectives**

According to Shipton (2001), the selection of the appropriate research methods for any study depends mainly on its objectives and questions. This is because the uniqueness of every study is contained within its objectives and researchers must use a relevant method, or mix of methods, to address these objectives. This chapter thus will begin by presenting the study objectives, which will be addressed using a qualitative research method, the phenomenological approach. The objectives of this study are the following:

1. To understand, from the perspective of non-Muslim nurses, what it is like to care for Muslim patients in Saudi Arabia, in relation to religion and culture.
2. To explore from the perspective of Muslim patients what it is like being cared for by non-Muslim nurses, in relation to religion and culture.

### **3.3 Research Philosophy**

There are three basic systems that all researchers must understand and accept: ontology, epistemology and methodology (Creswell, 2007; Savage, 2006; Patton, 2002). Hirschheim *et al.* (1995: 17) describe epistemology as “the nature of human knowledge and understanding that can possibly be acquired through different types of inquiry and alternative methods of investigation.”

As mentioned above, positivism, in general, is based on ontological concepts such as realism, the view that reality does not exist independently of the researcher’s experience (Cohen & Crabtree, 2006). Interpretivism, on the other hand, is cynical about positivism, and contends that reality is either a social construct, or our knowledge of reality is socially constructed (Walsham, 1995). Positivism is based on a realist ontology, and so is consistent with empiricist epistemology, which claims that the statements made by researchers in their

studies are true and can be deduced from unbiased, independent observation and experience (Varey, 2002a). One possible criticism of positivism is therefore that it is embedded in the researcher's independent observations. In general, positivists employ laws and quantitative methods in the prediction of dependent variables based on independent variables. Therefore the positivist paradigm is arguably not suitable for studying patient perceptions of nursing practices, because the resulting observations may not completely reflect patient views (Lutzen & Tishelman, 1991). Furthermore, it may not be possible to directly observe nursing practices communications with patients using positivist and statistical methods.

Therefore, although the positivist approach is an informative one, which provides helpful information and has its place in research, as a paradigm it is unable to describe nurse experiences in regards to particular phenomena. By contrast, interpretivist aims avoid this issue, because they seek to understand different situations and phenomena in a plausible way. Interpretivists attempt to identify the wider context, and make sense of information using qualitative research methods (Schultz & Leidner, 2002). Interpretivists depend heavily on phenomenology in general and hermeneutics in particular (Lee & Baskerville, 2003).

The interpretivist paradigm does not seek to draw objective conclusions, but instead aims at a subjective understanding through analysing patterns that emerge from the data. Interpretivism assumes that truth is determined through participants' perspectives, who better understand the world around them (Droth & Mehta, 2002). The role of interpretivist researchers is to elicit accounts of people's experiences in relation to a particular issue. However, interpretivism does not offer any type of causal explanation or suggest a relationship, as researchers intend to arrive at a theory rather than testing a pre-determined theory or hypothesis (Goldkuhl, 2012). Interpretivism seeks to reveal hidden patterns and factors, as reported by participants detailing their experiences and culture. Through using an interpretivist, approach researchers can understand the actions of individuals, which may enable positivists to identify the causes of particular events.

It is essential to take an interpretivist approach in this study, because it allows the researcher to understand the crucial and complicated relationships between non-Muslim nurses and Muslim patients. The interpretivist paradigm is also valuable in helping to understand the varying experiences of nurses who come from different cultures and religions.

As mentioned above, interpretivism interprets social and cultural life, and the world of people (Crotty, 1998). Phenomenology is one of the main interpretivist approaches; according to interpretivism, phenomenology is an approach that considers that the social and cultural world is constructed, and uses multiple methods to establish different views about a certain phenomenon. The phenomenological approach emphasises the importance of induction logic, and seeks to gather individuals' opinions and interpretations of a given phenomenon (Dahlberg *et al.*, 2001).

### **3.4 Quantitative and Qualitative Research Methods**

Research can be conducted using two different methods: quantitative and qualitative. Quantitative methods follow the positivist paradigm, while qualitative methods use the interpretivist paradigm (Robson, 1993). The decision to use one, or both, of these methods, depends upon the aims of the researcher for their study.

Quantitative research methods are those methods that aim to collect data that can be quantified and used for statistical analysis. Quantifiable data can be acquired through the comparison of different issues related to human beings, using different statistical techniques (Bryman & Bell, 2004). In general, quantitative research focuses on testing a hypothesis or theory, and demands a research strategy that emphasises quantification of data, in both the collection and analysis.

By contrast, qualitative research methods are based on words, so non-numerical narratives, and are associated with the interpretivist philosophy, which emphasises the way in which the world is socially constructed and understood (Blaikie, 2000). Qualitative methods generally use small-scale samples, and focus on the interactions between interviewers and interviewees (Philip & Dipboye, 1989).

Some scholars argue that there are significant differences between the two research methods (iLayder, 1993; Robson 1993). For example, Robson (1993) suggests that the main difference

between the two methods consists of their contrasting ontological positions. For example, qualitative methods focus on procuring an in-depth understanding of social or health problems and phenomena through the interactions between the interviewer and interviewee. On the other hand, quantitative methods address a social or health problem or phenomena from the perspective that the problem does exist (Bryman & Bell, 2004). The role of the researcher using quantitative methods is minor, and independent of the phenomena being studied. It can be concluded from this brief description that qualitative methods are more suited to exploring ‘why?’ and ‘how?’ questions, through examining the actual experiences of real people.

The above discussion of the comparative benefits of quantitative and qualitative methods suggests that the qualitative method is more suited to the research objectives of the current study. The research objectives are therefore instrumental in the researcher’s selection of qualitative research methods in general, and phenomenology in particular (see the choice of methodology section). This decision was due to the research’s belief that the study would provide nurses and patients the opportunity to recount valuable information regarding their experiences, and to express their views freely.

A qualitative research methodology was chosen for use in this study for three primary reasons. First, the research objectives require an in-depth understanding of patients’ views regarding the services provided by non-Muslim nurses, and qualitative research methods provide participants the opportunity to express their opinions freely. Second, the research seeks to establish certain truths about nursing services, and so depends upon the subjectivity qualitative methods allow for (Lo Biondo-Wood & Harber, 1994). Third, a qualitative method allowed nurses to speak about the problems they face on a day-to-day basis in the hospital, including challenges that hinder their performance, and cultural issues that impede their understanding of Islamic and Saudi culture.

### **3.5 Selection of Research Design and Methodology**

The selection of a research design and methodology depends on the research questions and objectives, as well as the circumstances of the study, rather than on the researcher’s personal preference (Hammersley, 1990). The choice of research design is also influenced by related literature, and the researcher’s prior knowledge and experience of the area being studied. Yin (2003) suggests that the research objectives direct the researcher in selecting the appropriate research design and methodology.

Speziale and Carpenter (2007) stress that before researchers can decide on the research design and method they must understand the philosophy that underpins each method. Furthermore, there are certain factors that must be taken into consideration when identifying the best method to answer particular research questions (Munhall, 2001); for example, Birks and Mills (2011) suggest that epistemological and ontological beliefs affect the researcher's understanding of the nature of reality, of who can be known and how they can be known.

### **3.5.1 Grounded Theory**

Grounded theory was introduced by Glaser and Strauss (1967), deriving from their study of the relationship between health care professionals and terminally ill patients. They had the idea of generating a new theory through the analysis of data pertaining to a particular phenomenon (Hancock, 1998). Glaser and Strauss (1967) classified grounded theory as a qualitative research method. Strauss and Corbin later define the grounded theory approach as:

“A qualitative research method that uses a systematised set of procedures to develop and inductively derive grounded theory about a phenomenon” (1990: 24).

This definition suggests that the grounded theory approach is a qualitative method that depends upon certain steps taken by the researcher to construct a theory based on data. The data collection procedures take the form of interviews and focus groups, and are organised in such a way that they produce theory, based on the patterns or categories that emerge. The resultant theory is grounded in the collected data, and was referred to as “grounded theory”. Due to the aforementioned distinctive characters, grounded theory is distinguishable from other qualitative methods, such as phenomenology and ethnography.

Grounded theory aims to unravel the various elements of an experience and analyse the connections between these elements, generating a theory from these relationships. Thus, the researcher is able to present the meaning of an experience in a particular situation (Strauss & Corbin, 1998). While grounded theory aims to investigate experiences and perceptions of these experiences, as well as stressing the importance of context, accepting that researchers are interpreters, elements which are all relevant to this study, its main aim is the generation or development of a theory (Holloway, 1997). The essential aim of the present study is not necessarily to generate theory, although this is also important, but to understand, from the perspective of non-Muslim nurses and Muslim patients, the experience of their interactions in



an unusual situation, more specifically, in a healthcare environment where neither nurse nor patient feels able to exercise complete freedom.

### **3.5.2 Ethnography**

Ethnography has its origins in anthropology, and literally means "portrait of a people"; it is predominantly utilised in studies that describe a culture, and in the context of healthcare it could be employed to understand how a person's cultural background might affect their perception of care (Hancock, 1998). However, this approach is arguably limited, because it examines how people are influenced by their culture and how they interact with other people from within the same cultural group (Hancock, 1998). By contrast, this study concerns the experience of non-Muslim nurses caring for patients from different religious and cultural backgrounds, and the main aim is to learn about their experiences in this context. More importantly, ethnography seeks to access the true nature of the object of study, to gain an understanding of cultural patterns and practices, and the collective behaviour of cultural groups (Fife-Schaw *et al.*, 2006), whereas this study seeks to understand the meaning of the experiences of those being studied, rather than their cultural context. Ethnography was therefore rejected as a possible research methodology on the basis of this limiting factor.

The ethnographic approach is considered to be a method that draws on multiple perspectives, which can be incorporated into one system design (Holzblatt & Beyer, 1993). One of the main characteristics of the ethnographic approach is that it requires intensive fieldwork. Anthropologists created the term "ethnocentrism" to refer to the tendency of individuals to think only from the perspective of their own cultures; according to Van Manen (1988), a good ethnographer is able to address the sensitivity of a particular culture, including their beliefs, values and practices, and compare this culture to others.

Researchers may begin their study with their research questions, or wish to explore the origin of a particular social problem. In doing so they might find that the research questions or problems they set out to address are not representative of the problems that their study participants actually face. Furthermore, the researcher may initially develop a theoretical model for the study and subsequently find that it is not consistent with their target participants or the field, requiring the researcher to modify and amend their research questions to better reflect the problems faced by the study participants (Le Comte & Schensul, 1999).

### 3.5.3 Phenomenology

Phenomenology is a traditional philosophical approach that was first introduced by the German philosopher Edmund Husserl (1859-1938). In 1913 Husserl defined phenomenology as a way of understanding how people describe experiences by reference to their senses; in essence, he assumed that people can only understand their experiences through perceptions and meanings that invoke their conscious awareness (Patton, 2002). Husserl developed the phenomenological approach because he felt that the positivist paradigm led to “inappropriate context-free generalisations of research”. Moreover, phenomenology was an attempt to capture the reality of individuals (participants in research) in their “life worlds,” and what this means (RCN, 1996: 19).

According to Patton (2002), phenomenology seeks an in-depth understanding of the meanings of experiences. The focus of a phenomenological investigation might be emotions, such as loneliness, jealousy or anger, and the phenomenon itself could be a relationship or work situation, such as a marriage or a job. The phenomenon could also be a programme, organisation, or a culture.

The phenomenological approach also aims to understand people’s experiences in relation to a phenomenon, and how those experiences are perceived; phenomenologists assert that a phenomenon can only be fully understood in light of people’s lived experiences of that phenomenon, and how these experiences provide an individual with meaning, and affect their perception of the phenomenon. Therefore, the primary goal of phenomenological research is to describe an experience and a person’s perception of that experience (Polit & Beck, 2004). As such, phenomenology is considered the most appropriate methodology for this study.

When Husserl and Heidegger initiated the notion of phenomenology, they linked its roots to epistemology and ontology. For this reason, the philosophy of phenomenology consists of either descriptive (eidetic) or interpretative (hermeneutic) approaches (Cohen *et al.*, 2000). In light of the ontological understanding of the researcher, and the philosophical and methodological underpinnings of this study, the interpretive approach will be adopted; the interpretive approach is appropriate for this study because it seeks to observe the nuances and the uniqueness of contextualised experiences (Swanson & Wojnar, 2007). According to Van

der Zalm and Bergum (2000), while it is not the case that hermeneutic phenomenology aims to prescribe action in a clinical context, it does have an influence on the introduction of alternative practices, by revealing the meanings of experience.

This study seeks to investigate the experiences of non-Muslim nurses caring for Muslim patients. According to Cohen *et al.* (2000) a phenomenological approach is suitable for research on nursing care, particularly when considering patient needs, something which this study aims to achieve. Furthermore, it is important to understand the needs of patients so as to ensure that they are met by nurses, a condition that is met through an understanding of the meanings that are attributed to experiences (Cohen *et al.*, 2000).

Phenomenology has been promoted for use in nursing research because the skills required for nursing practice and skills needed to conduct phenomenological research are complementary (RCN, 1996).

Although phenomenology is frequently used in nursing research, the concept is still confused, for two reasons. First, the phenomenological approach is not only a research method but also a research philosophy. Second, there are several styles of phenomenology, due to there being several phenomenologists and schools of phenomenology. However, all the various styles share certain commonalities. For instance, some authors have considered phenomenology to be a form of positivism, for example Husserl, while others have regarded it as interpretivism, such as Heidegger. According to Crotty (1996), phenomenology has recently come to be known as ‘new phenomenology’; he claims that there has been a transformation in nursing towards utilising the phenomenological approach, which is considered to be both a research method and a research philosophy (Dahlberg *et al.*, 2001).

Phenomenological methods have been used in nursing research since the 1960s (Van Manen, 1990). According to Lemon and Taylor (1997), phenomenology is employed in studying different aspects of individual experience, because as an approach it values the meaningful experiences of people. As such, the primary aim of phenomenology is to uncover, explore and describe specific phenomena. On this point, Van Manen (1990: 9 and 39) states:

*“Phenomenology aims at gaining a deeper understanding of the nature or meaning of our everyday experiences. A good phenomenological description that constructs the essence of something is constructed so that the structure of a lived experience is revealed to us in such a fashion.”*

It is clear that Van Manen's assertions are in line with those of Morse and Field (1996), who suggest that the aim of phenomenology is to explore the richness of individual experiences, in order to gather rich information about the issues being investigated. In relation to nursing, the phenomenological approach allows nursing staff to talk about their daily experiences of their interactions with patients, and vice versa. Halligan (2006) argues that the Husserlian phenomenology is the most suitable method for studying nurses' experiences of caring for Muslim patients.

A particular health culture exists in every society, and can be represented in the 'phenomenon of health' including such issues as health problems, illness, health services and so on (Reynolds Turton, 1997). Using the phenomenological approach, Struthers and Littlejohn (1999) conducted a study on nurses in the United States; the study argued that these nurses were working in a different and more sophisticated way than nurses in other cultures. Furthermore, Rytherstrm *et al.* (2009) conducted research seeking to understand and develop the concept of a caring culture; they used the phenomenological-hermeneutic approach to discover nurse experiences, interviewing 17 nurses and conducting follow-up focus groups discussions.

### **3.5.3.1 The philosophy of Martin Heidegger**

Martin Heidegger (1889-1976) was a student of Husserl; in his pursuit of answering the question of meaning, he came to criticise, modify and further develop Husserl's approach. Heidegger believed that people are hermeneutic, interpretive, and in this way find meaning in their lives (Swanson & Wojnar, 2007).

The main differences between the phenomenology of Husserl and that of Heidegger are that Husserl is descriptive and considers context to be of only a peripheral significance, whereas Heidegger's approach is interpretive, assigning context a central significance (Swanson & Wojnar, 2007). Moreover, Heidegger criticised Husserl's idea that meaning is completely neutral and is not affected by the researcher's own understanding (RCN, 1996). Heidegger also considered individual background to be an influence on one's understanding of the world and its contents.

Heidegger considered the object and the subject, as in the individual, to be inseparable, rejecting the idea that the subject was separate from the world. Heidegger represented this idea with the term 'Being-in the-world,' which he considered to be something *a priori*, meaning that it is not put together, but rather exists constantly, as a whole; he further argues that human beings exist only in the framework of an encompassing world (Mackey, 2005). Therefore, when considering the experience of caring, one should not ignore the lives of individuals outside of the caring environment, because their experience occurs within the context of family and community values, as well as a wider socio-political context (Swanson & Wojnar, 2007). There are a number of ways in which Heidegger considers that people are being-in-the-world, but the most important of these is an individual being aware of their own being, whereby they are able to think about their own existence. He refers to this as 'dasein' (Mackey, 2005).

As a particular philosophical approach, phenomenology provides methodological insights relevant to research, such as that the understanding of being must be approached in a certain way. Heidegger discusses time and space in relation to being, suggesting that "time is experienced as temporal and space as situated," and these philosophical insights should be reflected in interpretive phenomenological nursing research (Mackey, 2005).

### **3.5.3.2 Hermeneutic phenomenology**

Hermeneutic phenomenology is a research approach based on philosophical hermeneutics, as proposed by Heidegger. When seeking to understand the human experience hermeneutic phenomenology goes beyond core concepts and attempts to address the 'situatedness' of individuals in relation to their wider cultural, social and political contexts (Swanson & Wojnar, 2007).

Heidegger presented a hermeneutic phenomenology which aims to elicit an in-depth and meaningful interpretive understanding of everyday experiences, and is based on the idea that meaning can only be properly understood by those who experience it; for example, the approach does not ask: 'How do nursing students learn to nurse?' Rather, hermeneutic phenomenology would ask: 'What is the nature of the experience of becoming a nurse?' (RCN, 1996: 20). Hermeneutics is often used to classify sociological theories, such as phenomenology, where the focus is on both understanding and meaning.

As a research methodology, hermeneutic phenomenology is useful for describing the experience of caring in relation to the social and political forces that influence the perceived meaning of wellness (Swanson & Wojnar, 2007). The case has already been made that a phenomenological approach is justified in nursing research due to its ability to focus on the experiences of both nurses and patients in a care environment, and to consider a contextually meaningful experience (Annells, 1996). Furthermore, in relation to hermeneutic phenomenology in relation to nursing research, it is useful because it provides a link between hermeneutics and the active ontology of nursing, that is, that there are multiple levels of meaning in nursing (Annells, 1996).

The approach also considers the position of the researcher, and suggests that before the research is carried out, in regards to nurse-patient interactions for example, the researcher must reflect on their personal experiences of the care relationship their preconceptions and biases related to the care situation, as well as those brought to the investigation by the subjects themselves (Swanson & Wojnar, 2007). These factors are referred to by Heidegger as 'fore-structures', and consist of what is known by the researcher before interpretation takes place (Mackey, 2005). In the case of this study, which seeks insight into the experiences of non-Muslim nurses caring for Muslim patients in Saudi Arabia, the researcher is a Muslim Saudi nursing educator, and so it is recognised that the researcher brings prior awareness and anticipation of meaning to the research, as well as certain biases that must be considered. The process of interpretation begins when the researcher conducts the interviews and focus groups, and examines the transcripts. According to Mackey (2005), interpretation must go beyond literal meanings and should also include the aforementioned fore-structures, as well as any thematic meaning of the data.

In light of the ontological understanding of the role of the researcher and the philosophical and methodological underpinnings of this study, an interpretive approach is most suitable for this study. An interpretive approach is appropriate because this study seeks to identify the nuances and uniqueness of contextualised experiences (Swanson & Wojnar, 2007). According to Van der Zalm and Bergum (2000), while it is not the case that hermeneutic phenomenology aims to prescribe action in clinical experience, it does, however, have an influence in introducing an alternative practice by revealing the meanings of experience.

### **3.5.3.3 Distinction between Grounded Theory and Phenomenology**

The literature review documents substantial differences between grounded theory and phenomenology. The first key difference relates to the research question, where grounded theory aims to construct a theory from the collected data, whilst phenomenology focuses on the meaning, structure and lived experience of research participants (Patton, 2002). Grounded theory does not require the extensive literature review that usually precedes data collection, but still requires some review of extant literature (Suddaby, 2006). By contrast, phenomenological research methods require a professional review of literature to support the argument and design of the study (Moustakes, 1994).

In relation to data collection, grounded theory relies on interviews and observational social discussion with key people who can speak about themselves and others. The selection of participants depends upon the emerging hypothesis (Baker *et al.*, 1992). The phenomenological approach requires lengthy, unstructured interviews, and interaction between the interviewer and participants (Leedy & Ormond, 2005). In general, the researcher and participants will work together, during the interview, to uncover the heart of the phenomenon under study. In a study using grounded theory, the data analysis phase uses different types of coding and categorisation, which lead to the construction of a theory (Leedy & Ormond, 2005). The phenomenological approach focuses on identifying themes and connecting these themes to the interview text, which addresses participants' lived experience (Van Manen, 1990). Findings in grounded theory based research lead to a theory emerging from the data, while the findings of phenomenological research constitute a description of participant experiences (Morse & Richards, 2002). For grounded theory, researcher experience is an advantage, but a distinction should be made between researcher's (interviewer) knowledge that may affect participants' views during data collection. For phenomenological, the researcher must have substantial experience in the area under study, but should not affect the participants' perspectives (Leedy & Ormond, 2005).

As mentioned above, the objectives of this study are threefold. It is therefore difficult to use any research method other than phenomenology. First, the study does not aim to produce a theory on the basis of patterns and themes; its primary aim is to explore the experiences of nurses caring for non-Muslim patients, as well as the experiences of Muslim patients being cared for by non-Muslim nurses. The study required some prior experience of nursing services and caring models, in order to enable effective communication with nurses and patients. Accordingly, a phenomenological approach is essential, requiring the researcher to

possess previous knowledge of the topic being investigated, and a consideration of the position of the researcher. The present study involves interaction between the researcher and the nurses (Swanson & Wojnar, 2007).

### **3.5.3.5 Interpretative Phenomenological Analysis**

The analytical approach of “interpretative phenomenological analysis” (IPA) was developed by Jonethan Smith (1995). The main purpose of this approach is to explore idiographic subjective experience, particularly social cognition. The theoretical framework of the IPA is based on the phenomenology of Husserl, who attempted to construct a philosophical science of consciousness along with hermeneutics - the theory of interpretation. According to IPA, a researcher is engaged with participants’ views (interviewees’ transcript), which have an interpretive element (Potter, 1996). Additionally, IPA assumes an epistemological view, and thereby requires a careful and clear interpretation methodology. In other words, by using IPA, researchers can access the cognitive inner world of an individual.

Although the researcher does not explicitly use IPA, a detailed analytical strategy is presented, which explains all of the phases of data analysis, ranging from analysis whilst the data was being collected, to data transcripts, to use of what is called the “constant comparative approach”. The data analysis strategy also takes into account all measures to ensure the trustworthiness of the data collected.

## **3.6 Sampling Strategy**

### **3.6.1 Target group and the experiences of nurses and patients**

According to Rubin and Babbie (2001) a ‘population study’ is characterised by the sample target population under the study. The present study targeted non-Muslim nurses and Muslim patients. In reference to the target populations, the study examines the experiences of both nurses and patients in relation to the provision of health care.



### 3.6.2 Sample Size and Sampling Strategy

The appropriate sample size for a qualitative study is one that enabled the researcher to answer the research questions and objectives; therefore there is no standard method for determining correct sample size. A qualitative researcher is required to continue data collection until they are able to answer the research questions (Denscombe, 2003). For this study, the researcher decided not to limit the sample size of nurses and patients, as the intention was to elicit sufficient information about nurse and patient experiences. Examining interview transcripts on an individual basis enabled the researcher to focus on the amount and quality of information gathered, rather than on the number of participants.

Most qualitative studies use purposive sampling, which means selecting the participants who will be most beneficial to the study (Polit & Beck, 2004). Patton (2002) identifies a number of purposive sampling strategies that researchers can use to meet the needs of their research; one of these strategies, 'homogenous sampling', was chosen for this study. Homogenous sampling aims to obtain a homogenous sample in order to describe a specific sub-group (Patton, 2002), which for the current study is non-Muslim nurses caring for Muslim patients in Saudi Arabia, according to the research aims and objectives.

As this study uses interpretive phenomenological analysis (IPA) (Carty *et al.*, 1998), a smaller sample size was used. According to Darker and Larkin *et al.* (2007) a smaller sample size is recommended to be used in combination with IPA due to the in-depth nature of the enquiry, where if larger sample sizes are used this could lead to the loss of subtle meanings. Furthermore, qualitative research methods do not seek results that can be generalised to a larger population (Holloway & Wheeler, 2002). In other words, it is not necessary to draw a random sample from the target population. For this reason, there is no definitive formula or guide used to determine the sample size; the sample size depends upon how much information is needed and collected to achieve the study objectives. Therefore, the sample size for this study is based on the amount of data collected through the interviews and focus group discussions. However, it is still important for any researcher to be systematic when deciding on the composition group (Hollander, 2004). Therefore, for this study, the researcher selected a group of nurses with certain common characteristics, such as age, gender, educational level and years of experience. The nurses targeted by this study are of various different nationalities, but are all non-Muslim.

### **3.6.3 Recruitment of Nurses and Patients**

The recruitment of participants for research is critical, and so requires systematic procedures. As mentioned in the ethical considerations section, the first step of this process was to meet the Director of Research at the relevant hospital and discuss the study, including possible help in recruiting nurses and patients. The Director of Research was very cooperative and offered the name of the Head of the Nursing team, as well as a list of wards and nurses. The Director of Research personally spoke with the Head of the Nursing team, and the Heads of wards about the project and how they could assist the research. The researcher then received a formal letter from the Director of Research, giving permission to speak formally to patients and nurses. The researcher also spoke with the Head of Nursing and the Heads of relevant wards and departments in the hospital, excepting paediatrics, and the Head of Nursing helped in the identification of non-Muslim and Muslim nurses.

The third step was to visit the wards and make introductions with the Head of each ward, and discuss the PhD project. The researcher met with a number of nurses and informed them about the upcoming interviews and focus groups; potential participants then indicated their willingness to take part in the study, and the researcher enquired about their availability and access to patients. The response was generally that the patients were very friendly and would be cooperative; nurses from across different wards talked directly to patients, although many of them were visited by the researcher prior to the interviews. The sample size was 20 nurses and 8 patients.

### **3.7 Development of Interview Schedule for Focus Groups and Interviews**

The interview schedule was generally developed in accordance with the research questions and objectives, as well being informed by the literature review, and therefore the research could not progress without developing the questions to be asked during data collection. The interview schedule for the focus groups and interviews with nurses was developed to answer Research Question 1, and consisted of the following areas:

- Evidence of transcultural nursing education in academic studies
- Evidence of transcultural nursing education in practical training
- Feelings, opinions and insights of the experience of caring for Muslim patients
  - “Tell me about your experience of caring for Muslim patients”
  - “Is there a difference between caring for non-Muslim patients and Muslim patients?”
- Religion as a factor in the experience

- “How does religion affect care?”
- “How does religion (Islam) affect you, as a nurse?”
- “Is it easy for you to provide culturally sensitive nursing care?”
- Culture as a factor in the experience of caring for Muslim patients
- Communication as a factor
  - “Are there any communication barriers?”
  - “Do these barriers impact on your experience?”

The patient interview schedule was designed to answer the second and third research questions, and so covered the following topics:

- Opinions and feelings about being cared for by non-Muslim nurses
- The importance of religion in the care relationship
- The extent to which religious practical and spiritual needs are met
- Language issues

### **3.8 Data Collection Method - Focus Groups**

In the social sciences there are currently two primary methods of qualitative data collection, interviews and focus groups. Both of these were used in this study, which aims to examine, in depth, the experiences of nurses. The reason for adopting both methods was due to a perceived drawback of using interviews alone, where it was felt that the nurses would not speak freely in the specific context of this study; this is explained in more detail below.

Focus groups are considered suitable for gaining meaningful insight about experiences in various ways. Although it has been suggested by Morgan (1997) that focus groups cannot replace other, established qualitative research methods, they can provide a type of data that is not obtainable through those other methods, for example through individual interviews and participant observation. Researchers use focus groups to elicit perspectives on an experience, related to an area of research; recently they are increasingly used in the social sciences, and for qualitative health research (Holloway, 2008). One of the main advantages of focus groups is that they produce data through their group dynamic, which helps to stimulate thought and remind participants of their feelings (Holloway, 1997). This quality was judged advantageous for this study, as it would help to overcome the issue of power relationships, whereby nurses may feel reluctant to discuss with a Saudi Muslim nursing lecturer how Islam features in their experience of caring for Muslim patients.

Conducting interviews is a common and powerful way to try and understand human beings, and are therefore an important part of sociology (Denzin & Lincoln, 1998). This study used semi-structured interviews, first because they help to gain a deeper insight into experiences, and second, because they are a flexible approach to gathering data, allowing the researcher to direct the flow of information (Polit & Beck, 2004), something that is required by the phenomenological approach. The researcher took careful consideration to find the correct balance between allowing a participant to relate their experience, according to the phenomenological approach, and the need for a loose agenda that would maintain a focus on the phenomena. Although semi-structured interviews are of course more structured than unstructured interviews, the informants are still able to relate their experiences in their own time and their own words (Holloway, 2008).

### **3.8.1 Focus Groups**

In previous decades, most writing on the use of focus groups has been from the perspective of marketing research; however, in more recent times, research using focus groups can be found in a wide variety of areas such as education, anthropology, nursing studies, political science, communication studies, sociology and education (Morgan, 1997). Qualitative research must be designed in such a way as to be able to collect descriptions of lived experiences whilst retaining spontaneity, and although this is often achieved through interviews, group discussions have also been used to this end (Jasper, 1994). Focus groups can be employed as a primary research method, referred to as a self-contained method, or in combination with other methods (Morgan, 1997). In this study, focus groups were used alongside semi-structured interviews to overcome the limitations of the strong power relationship that exists between the researcher and the participants in individual interviews.

Phenomenology is an approach often employed by nursing researchers, as is the use of focus groups. It has been argued by Bradbury-Jones *et al.* (2009) that individual lived experience can be preserved within a group setting; however, they do caution that if researchers combine focus groups with phenomenological research they should maintain critical awareness throughout. In this regard, the present study has used focus groups due to the power relationship between a Muslim Saudi nursing lecturer and non-Muslim nurses in a Saudi setting; this relationship may prevent nurses from opening up and speaking freely,

something contrary to the aims of phenomenology, which seeks to establish the essence of phenomena through uncontaminated description (Bradbury-Jones *et al.*, 2009). The nurses needed to be able to speak freely without fear of judgement or potential negative consequences in relation to their career. It is not difficult to imagine why a nurse working in a conservative religious society being interviewed by a Saudi nursing instructor might be careful about what they revealed.

Not only are focus groups beneficial for phenomenological research because they reveal new perspectives and stimulate discussion (Bradbury-Jones *et al.*, 2009), but in the context of this study it was also found that the nurses were more confident in expressing their feelings, particularly regarding experiences related to religion, due to the presence of other nurses also present in the focus group setting. Prior to the field study the researcher was very aware of these issues, and that potentially some of the nurses would not speak freely in semi-structured interviews, and so focus groups were used to gain a deeper insight into their experiences.

One of the main advantages of focus groups in comparison to other methods of qualitative data collection is that they provide participants with a more natural environment as opposed to, for example, individual interviews and observation (Litosseliti, 2003). It was evident during the data collection that a focus group setting was beneficial to this study, as in each group there was one nurse who spoke more openly and introduced particular issues, which encouraged others to speak more freely.

Although it may seem that the groups themselves form the most important part of the project, they are in fact just one element of the research method. In order for the research to be successful it must be conducted carefully, and a significant issue is how to store and process the data that is obtained from the groups. The interview technique is also important (Morgan, 1998a).

The main advantage of focus groups in comparison to other interview techniques is that they allow the researcher to observe the interactions between participants, which according to Litosseliti (2003), provides an insight into how individuals are influenced by other participants, indicating the group dynamics. Focus groups expose the similarities and differences between the experiences and viewpoints of multiple participants, which are recorded as they are revealed. Litosseliti (2003) argues that focus groups also reveal the shared understanding of a particular subject, and help to generate new ideas about a subject

through brainstorming. In the present study, all the participants shared similar everyday experiences in the same context, that of being a non-Muslim nurse caring for Muslim patients in Saudi Arabia.

### **3.8.2 Development of the Focus Group Instrument**

Sufficient planning of a focus group is essential. It has been suggested by Litosseliti (2003) that if there is not enough time or resource available then focus groups are not a viable method, as they require a significant amount of both time and resources, as well as an experienced moderator. A focus group is not merely a haphazard discussion; it should be a well-planned research instrument, as with other research methods. There are two critical aspects to be considered, the design of the interview guide and the recruitment of suitable participants (Stewart *et al.*, 2007). The latter will be discussed below.

The questions to be asked in a focus group should reflect the research questions of the study, and should be designed in such a way that they provide direction for the group discussion, serve as the agenda and generate significant discussion among the participants (Stewart *et al.*, 2007). However, when deciding on the structure of the focus group it should be considered whether the discussion should focus only on pre-determined topics suggested by the moderator, or if the discussion should be directed by the participants (Morgan, 1998b). For the present study the aim was to be exploratory, and therefore a less structured approach was taken in order to reveal the relevant issues and insights, and to understand the interests and concerns of the participants.

Although the questions asked in a focus group appear to be unstructured and spontaneous, they are in fact carefully planned, follow a particular sequence and are open-ended (Litosseliti, 2003). The more important questions should be asked first, and more general questions should precede more specific questions. For example, in the present study, the following question was asked: “How do you feel about caring for Muslim patients?” Although it may seem counter-intuitive, it is possible to begin with a general question about one particular topic, followed by a more specific question, before moving on to another topic (Stewart *et al.*, 2007). The reason for this sequencing is to create a broad but focused discussion around the topic, in order to achieve the goals of the focus group (Litosseliti, 2003). However, there should be a degree of flexibility within the structure. Care should also be taken in the development of the questions themselves; they should be written in such

a way that they are easy for the moderator to ask without stumbling or confusing the participants, they should also be short and open-ended (Krueger & Casey, 2000).

Overall, a focus group does have the potential to gather qualitative data for this research. However, this potential can only be realised if attention is paid to the aforementioned methodological issues. Sim (1998) reminds researchers that a number of issues will affect the effectiveness of the research instrument

### **3.8.3 Sampling for Focus Groups**

The sampling and recruitment of a focus group is another critical area of this research methodology, as problems relating to recruitment are the single greatest cause of focus group failure (Morgan, 1998a). The other skills required for the success of a focus group, such as moderator skills, carefully written questions and overall preparation, are not valuable if the right participants are not in attendance (Krueger & Casey, 1994).

When conducting focus groups it is very important that those who are invited to participate are both willing and able to give the required information; they should also represent the overall population that is being studied. For this reason appropriate sampling is critical (Stewart *et al.*, 2007), as the composition of the group has a significant effect on the group dynamic; for example, a group consisting of parents and children will produce a different outcome than a group of just parents. It is true that there must be a degree of homogeneity among the participants, however, there should also be a degree of variation, so that contrasting opinions can be represented (Krueger & Casey, 1994). In the present study, these conditions were satisfied; although the participants were all non-Muslim nurses at the King Faisal Speciality Hospital, there was also some variation, as they worked in different departments and had different levels of experience and qualifications.

The size of focus groups is traditionally between six and twelve participants, or, in the case of marketing research, ten to twelve. Any more than twelve is not recommended, as participants will have limited opportunity to express their views and share insights about their experiences (Krueger & Casey, 1994). For this study, there were three focus groups; two groups of four participants, and one group of three. All the participant nurses hold positions in medicine, obstetrics, gynaecology and surgery; their length of nursing

experience was at least one year's practice in one of these areas, with a required certification of a Diploma or Bachelor's degree in nursing.

### **3.8.4 Piloting of Focus Groups**

The piloting of focus groups is different to that of other research instruments; for focus groups the piloting must consider the characteristics of the participants, the nature of the questions, participant interactions and moderator procedures. Furthermore, according to Krueger & Casey (1994) it is advisable to have an expert to review the questions, as well as potential probing questions; or, as an alternative, they can select participants, or people who meet the same criteria, to provide comments on the questions.

The piloting of the focus group for this study was conducted by inviting three nurses meeting the same criteria as the actual participants to take part in the pilot. The researcher checked the clarity of the questions and observed the direction the discussion took as a result of the questions. Moreover, the researcher also sought the opinion of the participants regarding both the specific questions and the discussion more generally. The pilot study was also conducted at the same location as the actual focus groups.

### **3.8.5 Conducting the Focus Group**

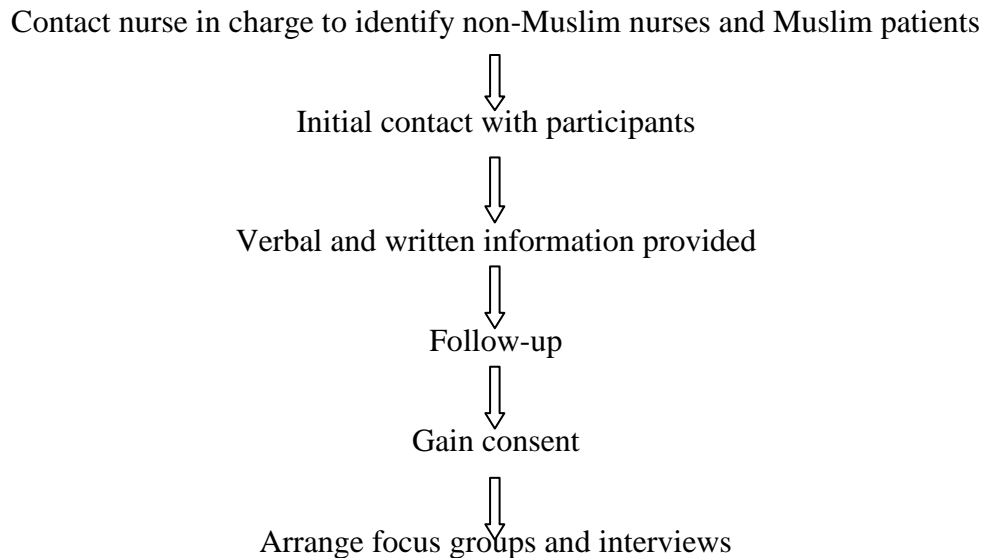
Prior to conducting the focus groups, permission was sought from the relevant department in the hospital. The Head of Nursing for different wards, except for paediatrics, identified the non-Muslim nurses, and determined whether they were interested in participating. Once this identification had taken place the researcher was able to distribute the documents relating to informed consent and participant information to the relevant nurses. Thereafter, they were informed about the times and dates of the focus groups and interviews, and invited to attend.

The focus groups began with broad questions asking the nurses about their experiences, and the researcher then responded to clues and issues that were raised. Each focus group lasted approximately 50 minutes; all focus groups were audio recorded and transcribed verbatim following each session, and notes were made regarding the ease of interaction and any non-verbal communication. Once the tapes had been transcribed, a copy of the typed transcript was given to each participant to read, and they were invited to make additions, deletions and/or corrections, in line with the requirement of hermeneutic interpretive phenomenology to return to the participants to clarify any disagreements in the interpretation of the narrative



(Swanson & Wojnar, 2007). Data was anonymised and coded for purposes of analysis, and was stored on a password protected computer accessible only by the research team, which will be destroyed upon completion of the project.

Fig.3: Recruitment procedure



The location of the focus group is another important factor, not only because it will have an influence on the dynamics of the group's interaction, but because it also makes recruiting participants easier. More specifically, the location should allow the researcher to gather the data, the participants must be able to hear and see each other, there should be minimum disruption, and the location should be comfortable, and in a convenient place (Morgan, 1998b). For this study, the focus groups were held in the hospital, as the nurses live in hospital accommodation, on site, and it was important not to disrupt their working and social life any more than necessary. Another important factor influencing the dynamics of is the physical arrangement of the group. It is recommended by Stewart *et al.* (2007) that participants should be seated around a table because it adds a sense of security and comfort. Therefore, this physical arrangement was adopted for this study, and four focus groups were conducted within the target hospital.

After deciding to use focus groups as a data collection method, for reasons already explained, that a Muslim researcher interviewing non-Muslim nurses primarily regarding religion and its place in nursing practice may impede a full discussion., The reason for the change in method, after arguing strongly for focus groups, was purely a pragmatic one; as a researcher fully

engaged with the research, it was possible to more readily engage, on a one-to-one basis, with the nurses at a time convenient to them, recognising their clinical responsibilities.

### **3.9 Data Collection Method - Interviews**

One of the aims of this study is to understand the experiences of care for nurses and patients. In relation to this aim, it has been suggested by Seidman (2006) that interviews are not simply about answering questions, but about understanding the lived experience of the interviewees.

There are a number of different forms that qualitative interviews can take, such as unstructured, semi-structured and structured interviews, which generally provide quantitative data. Although the difference between unstructured and semi-structured interviews is important, it is artificial and derives from strategies arising from different disciplines (DiCicco Bloom & Crabtree, 2006). This study employed semi-structured interviews because they are judged to be useful for reconstructing events and experiences in a healthcare setting (DiCicco Bloom & Crabtree, 2006).

As stated earlier, this study utilises a phenomenological approach; phenomenological interviews can provide a framework around which numerous types of qualitative studies are based. However, the intention is not to try and provide an explanation or theory, rather it is to understand shared meanings by gaining a vivid account of the lived experience of individuals. The interviewer therefore should endeavour to gain a description from the respondent, rather than trying to interpret their experience (Sorrell & Redmond, 1995).

#### **3.9.1 Semi-Structured Interviews**

It was decided to use semi-structured interviews in order to maintain a focus on the aims and objectives of the study during the interview. However, care was taken that the predetermined questions were flexible enough that the participant was able to speak freely. In other words, the schedule of a semi-structured interview does not have to be strictly adhered to, allowing the interviewee, rather than the schedule, to guide the interview (Griffiths, 2009). Smith *et al.* (2009) state that researchers use an interview schedule for IPA to set a loose agenda, where questions regarding an experience can be asked in the order that the researcher may expect, or the researcher can create a virtual map that can be used the conversation become stuck.

Although unstructured interviews are often used in phenomenological research, there is still a need to keep the phenomenon in focus. For example, in a study conducted by Fareed (2006) unstructured interviews were used, but also a semi-structured guide, to maintain a focus on the aims of the study. Moreover, this guide ensured that all of the areas were covered (Fareed, 2006). May (1991) observes that semi-structured interviews are organised around ideas of interest, while at the same time allowing flexibility in scope and depth.

The use of predetermined questions based on the focus of the study is also supported by DiCiocco-Bloom and Crabtree (2006), who say that the basic research question of the study can be used as the initial interview question, followed by a number of more specific questions, between five and ten, which probe more deeply into different areas of the research issue. If it is found that the questions are not eliciting the required information, then the researcher should be prepared to abandon those questions, or they should be prepared to deviate from the itinerary, as this may elicit greater information.

Above all, it is important to focus on the nurses' experiences; however, there are predetermined aims to the study, and according to Fife-Schaw *et al.* (2006: 329) "IPA studies require a flexible method of data collection, one which gives experience a central place whilst recognising the multiple influences on any experience: its historical and cultural situatedness, including language and social norms and practices". Fife-Schaw *et al.* (2006) also observe that most IPA studies are conducted using semi-structured interviews, which is ideal for IPA research. Thus, in light of the above, it is clear that semi-structured interviews offer the flexibility required for IPA.

The researcher is not completely neutral in this process, because they are informed by previous knowledge and experience (May, 1991). It must therefore be acknowledged that the researcher in the present study is a nursing instructor with experience in the study area, and must consequently be careful about contaminating the data (Jasper, 1994). According to Polit and Hungler (1995) the researcher's subjective judgement can actually be valuable in phenomenological research, although it should be remembered that both Jasper, and Polit and Hungler, agree the interviewer should use clarification, reflection and ask for examples when researching a subjective experience (Wimpenny & Gass, 2001). Although this would seem to be more in keeping with an unstructured approach, the researcher adopted a semi-structured approach due to the need to have an interview guide ensuring that the research aims and

objectives are achieved, namely exploring the experiences of caring and identifying issues in training and development.

Hancock (1998) suggests that the interviewer should aim to discuss a limited number of topics and frame questions according to the response given to the previous questions; it should be remembered that the aim is to cover a broad area in detail.

### **3.9.2 Development of the Interview**

The approach to the interview technique used in this study was again a phenomenological one. Using this approach interviewers generally ask open-ended questions, with the primary aim of further exploring the responses to these types of questions, so that the interviewee can reconstruct their experience in the area under study (Seidman, 2006). In a similar fashion, it is recommended that focus groups use a questioning route to control, to an extent, the structure of the discussion. It is recommended by Patton (2002) that interviewers use an interview guide, consisting of a list of questions or issues that need to be investigated in order to ensure that a consistent line of enquiry is followed. This idea is supported by Mason (2002) who argues that although the researcher is conducting an interview which is semi-structured, and so may feel like a conversation to the interviewee, this does not mean that the researcher does not need to carry out detailed planning.

The fact that the researcher is a Muslim, interviewing non-Muslims, meant that cultural and religious barriers had to be overcome. It has been suggested by Sands *et al.* (2007) that cultural differences between the interviewer and interviewee can have a significant impact on the interviewer's ability to facilitate a meaningful conversation. These authors also suggest that interviewees may feel threatened by the interview process, and therefore be reluctant to answer certain questions if they feel vulnerable or uncomfortable with being asked about particular topics. A reluctance to answer may also be due to concerns that the interviewer is from the dominant culture, in this case a Muslim Saudi, and will use the interview to further legitimise perceived inequalities in the workplace. Therefore, before commencing the interviews, the interviewees were made fully aware of the aims of the study, and told that the results would be anonymised, in order that they would feel able to relax and speak freely. This process is something that is also recommended by Sands *et al.* (2007), what they refer to as 'transparency'.

### **3.9.3 Sampling for Interviews**

Interviews were held with eight patients and twenty nurses. The patients were selected from the aforementioned wards, and the selection of nurses was divided equally according to level of education, as it was for the focus groups. However, it was important to speak to different nurses than took part in the focus groups, as the researcher sought to gain an original perspective, which could not be obtained by using the focus group participants, as in the interviews they may have repeated information already revealed during the focus groups; moreover, the nurses may feel compelled to reveal the same data in order not to appear contradictory.

### **3.9.4 Piloting of Interviews**

It has suggested that there are unexpected “twists and turns” (Seidman, 2006: 39) in the interviewing process, and therefore that there is a need to explore this process beforehand, to allow the researcher to confirm whether it is conducive to the aims and objectives of the study (Seidman, 2006).

Conducting experimental tests of the complete interview can be time consuming, therefore, as suggested by Polit and Beck (2004), it is advantageous to conduct a small scale test to check the feasibility of the research instrument; this could include a test of acceptability as judged by the participants, and the viability of conducting the interviews in a hospital setting.

The piloting for this study involved conducting two test interviews, the participants for which fit the same criteria as set out in the sampling section.

### **3.9.5 Conducting Interviews**

The duration of the interviews was approximately 90 minutes each; the main reason for this length of time is that the researcher sought to gain an in-depth insight into the participants’ experiences. According to Seidman, (2006) 90 minutes is an appropriate interview length, as one hour will encourage respondents to be conscious of time, and two hours is too long; by contrast, 90 minutes is enough time for the participants to reconstruct their experiences and situate them into the context of their lives.

In terms of the location, the same considerations were taken as for the focus groups, in that the location should be peaceful, comfortable and convenient for the participants, and so the interviews were conducted in the hospital.

### **3.9.5.1 Conducting Interviews with Nurses**

Before conducting each interview, each nurse signed a consent form. In order to build a rapport with the nurses, the researcher began the interview by asking questions such as: “When did you come to Saudi Arabia? How do you find it here?” This was done to break the ice and as a warm up before asking the interview questions. Once the researcher had asked the introductory questions, the main questions were introduced. The researcher also used probes that encouraged nurses to give examples from their experience. In general, the researcher adhered to the questions outlined the interview schedule, in order to explore the main issues of religion, culture and language in a consistent manner. In general, semi-structured interviews are flexible and provide an opportunity for dialogue between the interviewer and interviewee (Rubin & Rubin, 2005). At the end of each interview, the nurses were thanked for their time and participation in the study.

### **3.9.5.2 Conducting Interviews with Patients**

In general, the researcher used the same method of interviewing that was used with the nurses, and each patient signed the consent form. At the outset of each interview the researcher described the nature of the PhD research, its objectives and benefits to patients. The researcher also tried to build a rapport with patients by asking them general questions about their health, their experience of the hospital, and so on. Questions about their relationship with the nurses and doctors were then introduced, such as how non-Muslim nurses interact with and treat them. The interview schedule consisted of four main questions related to religion, culture, language and communication. In general, patients were very cooperative and provided in-depth information about their experiences and the care provided by non-Muslim nurses. All patients were thanks for their participation in the study, and their time.

## **3.10 Data Analysis Strategy**

Phenomenological data analysis aims to understand the data and gain a clear understanding of its meanings, structure and the lived experience of individuals and groups of the phenomenon under study (Patton, 2002). The present study aims to explore nurse and patient experiences of receiving and providing services, which requires transforming participant experiences into research findings.

The data analysis commenced with examining the transcribed focus groups and interviews line by line, as digesting all the information is important to fully understand the data. According to Dey (1993), reading is the core of data analysis because it helps the researcher to focus on the main themes emerging from the data. In the data obtained in this study, the main themes emerged during the collection process, and were consistent throughout the reading process. Furthermore, ideas about the direction of data analysis began to emerge alongside specific patterns and themes. The reading and re-reading of the transcripts provided the researcher with the opportunity to identify nurse and patient thoughts, feelings and experiences.

In relation to qualitative data, the role of the researcher is to make sense of the data through exploration and interpretation. The analysis of qualitative data begins during data collection, and this process continues but is modified throughout the data collection and analysis stages; analysis also enables links to be made between the amount of data and the conclusions drawn (Stewart *et al.*, 2006). The main goal of the analysis stage of this study is to identify commonalities between nurses and patients, leading to the categorisation of data into themes, or codes, and to search for comparisons and contrasts. The following section will present the data analysis strategy employed in this study.

### **3.10.1 Data Saturation**

Data saturation occurs at the point at which no new themes emerge from the transcripts of interview data (Parahoo, 1997). The data saturation point is critical for assessing qualitative data, as failure to achieve saturation may hinder the achievement of quality results, and so affect the research validity. As mentioned above, qualitative researchers usually use purposive sampling, whereby it is not necessary to pre-determine the sample size of a study. A researcher might collect data from fifty participants in order to address the research objectives and questions. Therefore, data saturation depends upon the richness of the data gathered, rather than on the amount of data (Carey, 1995).

Existing literature documents two types of data saturation, descriptive and theoretical. To achieve descriptive saturation, a researcher will not be able to find any further descriptive themes, codes or categories emerging from the data. On the other hand, to ensure theoretical

saturation, a researcher must not only to ensure that the analysis describes the data, but also explain how the themes and sub-themes interconnect (Charmas, 2006).

For this study, the researcher used theoretical data saturation, because a constant comparative approach to data analysis helped to reach data saturation and data redundancy. A constant comparative approach was used in such a way that the researcher could compare different pieces of interviews that were relevant to the themes and sub-themes emerging from the data. After reading the transcripts of five interviews and one focus group, nine main themes, and thirty-nine sub-themes emerged from the data. The researcher then revisited the interview transcripts and found that these themes and sub-themes answer the research questions.

### **3.10.2 Analysis of Interviews and Focus Groups**

The analysis process of focus group data is different from the analysis of interviews, due to the interaction that takes place between participants; this difference is reflected in the different views of participants in the focus groups. Gussy *et al.*, (2006) suggest that analysing focus group data should take the group dynamics into consideration, which may generate more insight. The level and process of data analysis depends upon the study objectives being investigated, and the complexity of phenomenon under study. When analysing focus group data, Duggleby (2005) suggests that a focus must be placed on the social constructivism of reality and meanings, as well as the categories that frame the everyday lives of individuals.

This study addresses nurses' lived experience in relation to patients and everyday experiences in the hospital context. Therefore, in the analysis of the focus groups conducted with nurses, the main issue was how nurses discussed different factors, such as religion and culture. In each focus group, nurses reached some agreement, but disagreed on other issues, such as training in the Arabic language and Saudi culture (see Chapter 4, Study Findings).

### **3.10.3 Transcription and Organisation of Data**

The first step for all types of qualitative data analysis is to transcribe the data, such as the interviews and focus groups. Transcription of data is beneficial in documenting data for future use over extended periods. It is not always necessary to complete the transcription process on the first listen, as gaps and missing words may be detected later (Stewart & Shamdasani, 1990). For this reason, the researcher listened to the digital tape recording



several times to check spellings and sentences. Morse and Field (1995) stress that if information is missing from transcriptions, this may confuse the reader and obscure the meaning of sentences and phrases. The researcher transcribed the focus groups and interviews, which contained patient and nurse views and addressed various issues, such as the Islamic religion and Saudi culture.

#### **3.10.4 Thematic Analysis**

There are various methods of analysing qualitative data, including thematic analysis and content analysis. Content analysis evaluates the relevance and frequency of certain words and phrases, and counts words that can be associated with other key words emerging from the data (LeCompte & Schensul, 1999). One drawback of content analysis is the summarisation of mass collected data into comparably brief results; for this reason, this method is mainly used for documentary analysis (Bernard & Rayan, 1998).

On the other hand, thematic analysis is used in both health and social sciences. Thematic analysis does not depend on counting words and phrases, but instead focuses on describing the ideas and thoughts emerging from the focus groups and/or interviews. The main advantage of thematic analysis is that it allows for the categorisation and coding of emerging patterns or themes from the data. Moreover, thematic analysis can be combined with a constant comparative approach in order to compare participant perspectives (Wright, 1997). In this study, thematic analysis is used to extract the core meanings of nurse and patient experiences by defining specific themes and sub-themes emerging from the data. These themes and sub-themes reflect the participants' experiences (Smith *et al.*, 2009).

#### **3.10.5 Coding and Categorisation**

The coding of focus group data is critical, as it helps to make sense of participant experiences. Coding is the second step, after the transcription of interviews and focus groups. Coding moves the data from being a large-scale statement reported by participants to a more abstract interpretation of data (Chamaz, 2006). For this study, the data coding followed the thematic analysis approach, as mentioned above. The researcher used two types of coding, open coding and focused, or selected, coding (Strauss & Corbin, 1998). When carrying out the open coding, the researcher read the interview and focus group transcripts line-by-line, assigning a label to each line. However, open coding was not sufficient, as it produced

numerous labels and themes. Therefore, focused, or selected, coding was applied to several lines and paragraphs in the interview and focus groups transcripts. These codes required the researcher to identify the themes that best represented nurse and patient experiences; the themes, or codes, were then attached to statements reported by nurses and patients. Many issues emerged from the data that are considered important in addressing the research objectives and improving nursing services in Saudi hospitals. Table 3 presents the main themes and sub-themes found in the analysis of data.

### 3.10.6 Constant Comparative Approach

The study used what is called a ‘constant comparative’ approach to data analysis. This approach helped the researcher to compare the views of nurses and patients. The main advantage of this approach is that it complements theoretical and purposive sampling; this advantage corresponds with the researcher’s decision regarding the number of interviews and focus groups they intend to conduct. In this way, the researcher is able to pursue questions that are related to the interpretation of the phenomenon (Boeij, 2002). This cannot be achieved without categorisation of data, or segments; the data is then analysed and the segments of interview data is compared with segments from the focus groups. In this study, patient views were compared with nurse views in regards to perceptions of nursing care, and common views among patients and nurses were identified. This comparison of patient and nurse views increased the internal validity of the results (Buedo and Miller, 2010). When the study sample is homogenous, it produces valid results and suggests the generalisation of results. The data obtained from the interviews and focus groups conducted in this study provided rich input for analysis, helping to make sense of the data and reconstruct nurse and patient perspectives.

**Table 2: Attachment of themes and sub-themes to text**

Themes	Sub-themes	Example of Text
Understanding Islam	Importance of religion to patients	We were not allowed to eat in front of patients during Ramadan
	Respect of Islamic traditions	So now I have tried to convince myself in a way that I am in a Muslim country and I should respect the laws or traditions followed here if I want to stay. In this way, I have overcome these kinds of things.
	Prayer times	I respect prayer. You know when it is prayer time you should respect it.

	Confusion between religion and culture	<p>Some patients are sitting on the floor, which I think is their culture but this is not medically good for patients. So I think sometimes the religion affects the care.</p> <p>So, we do not get that much information about different cultures and religions during our studies.</p>
	Religious sensitivity	<p>I had a patient who was 65 years old or something; he was intubated and he has very long beard.</p> <p>I asked his son through a translator whether I could shave his beard because it was not hygienic.</p> <p>The next day when the women from the family came they were crying as if I had killed him and he would not live anymore.</p>
	Religious phrases and supplications	<p>The patient feels good when we use these words; they feel good when I say "Bismillah".</p> <p>I think using these words, for example 'Bismillah', makes the patients feel more comfortable.</p>
Professionalism	Impact of religion on professionalism	<p>I do not judge patients based on their religion or culture, but I judge the patients based on their personalities and their behaviour towards me.</p> <p>I have no particular feelings about whether the patients are Muslims or of any other religion; it doesn't bother me.</p>
	Defending professionalism	<p>To provide care it does not matter, because you have to give the best care as a professional nurse. You only have to consider that they might need things for their religious duties, but their religion does not affect the kind of care you give to patients.</p> <p>We just take care of patients of every religion in a professional way so that the level of care is the same for all patients, whether Muslim or non-Muslim.</p>
	Patients' feelings about professionalism	<p>Even if he is non-Muslim and well qualified I would prefer him to work with me rather than an Arabic one. I can say nothing if there is anyone else.</p> <p>If a Saudi nurse does not reach the required level, I would not prefer her, of course. I mean that if the Saudi isn't sincere in her work I cannot favour her.</p>

	Saudi nurses versus non-Muslim nurses	<p>When working maybe foreigners are a little better than Saudis. Foreign nurses may be more familiar with this work, so their skills are better.</p> <p>You feel that the Saudi nurse is hesitant and not confident in herself, and she always asks her colleagues, but the foreigners are more confident in themselves and in what they are doing.</p>
Nurses' ability to carry out care duties	Effect of prayer on care	Certainly there are prayer times. When we first got here we were told that you have to stop doing important care because people wanted to pray. Initially I found that somewhat difficult because surely your health and being alive is more important than absolutely having to say prayers right now.
	Muslim females wearing the hijab	I work in oncology taking care of patients receiving chemotherapy. The only problem I have encountered is that female patients are covered, even when they are in bed, so we cannot see if the patient is cyanotic because they are wearing abaya.
	Physical contact with patients	As a female nurse, they gave me male patients to work with. For example, if I have to clean a male patient, it is really very difficult and embarrassing for me, and also for the patient. Sometimes, I have to clean the private areas of male patients as well.
	Patients' families are a barrier to care	<p>I work in orthopaedics where we try to make the patients independent. Here I have noticed that when we have such a patient and we are trying to make him independent on his own, his family is there, and they just want the patient to rest in a wheelchair, or on a bed, and they do everything for the patient, which makes it difficult for a patient to become independently mobilising.</p> <p>As far as the communication with the family goes, I think sometimes we face difficulties regarding the patient's family or sitters interfering with our care, sometimes refusing the things we want to do. I think this is due to things not being well explained, or interpreted, to them in the same way that we want to do things.</p>
	Transgression and accusation	Yes, I am a bit more of a relationship maker but you are always being told to be aware of

		<p>your relationships, which means... You came into Saudi Arabia in the first place, so you do not want to be accused of doing something inappropriate, so it is sort of always keeping a professional distance, but a bigger professional distance than I ever kept with any of my patients in the Western world because of asking them things I would consider inappropriate. Therefore, you do not actually know where the professional barrier is. I can easily judge a person in the Western world, but here I found this a lot harder to do, and if I do it like this, I will be out of here.</p>
Language barriers	Understanding the Arabic language	<p>We cannot speak to them because we cannot speak the same language, they would not take them off to even start some short communication and it puts up a barrier between yourself and the patient.</p> <p>I think that in my country you and the patients can better understand each other, because we have the same language, but here sometimes language is a barrier.</p>
	Communication	<p>I think the most common difficulty here with patients, which we all face, is the communication and language barrier. We cannot communicate with patients in their own language and sometimes they are unable to understand what we want them to do.</p> <p>As far as the communication with the family goes, I think sometimes we face difficulties regarding the patient's family or sitters interfering with our care, sometimes refusing the things we want to do. I think this is due to things not being well explained, or interpreted, to them in the same way that we want to do things.</p>
	Impact of language on care	<p>They do not follow our instructions, like walking, ambulating; they prefer to sleep and just lie down. So, language is a barrier, which I think if I were able to speak Arabic, I could communicate better with patients.</p>
	Preference of Saudi nurses	<p>Because they understand my speech.</p> <p>Yes, their language may be not understood; if two of them are speaking I cannot understand what is going on between them.</p>
	Translation problems	<p>I do not know why a translator is not</p>

		<p>available now; maybe there is lack of staff. Due to this, I sometimes find a person who can speak Arabic and explain to the patient. Sometimes, if there is no one around, I have to wait for somebody to come and explain to the patient.</p> <p>I hear “Bismillah” and I hear sometimes patients say “Akul” “Akul,” and I do not know what “Akul” is. I asked one of the ward clerks what Akul is, and they said that he is hungry and wants food. He taught me that word and now I know it in English and Arabic. So, you just keep running in and around asking what a word means.</p>
Workload and scheduling (busy-ness)	Prayer effect on nurses workload	<p>Sometimes there is a problem with time management, as sometimes the patients and their families are praying together. It may take too long and we have to wait until they finish their prayer.</p> <p>Also, here there is a prayer time and if you want to give some medication or treatment to the patients, or if they have an appointment, they will first ask us to allow them to pray, then they will be prepared to go with you.</p> <p>Also, the patients pray before the procedure for 15 or 30 minutes, so these all delay procedures.</p>
	Impact of fasting on workload	<p>For me there is no difficulty if the patient is Muslim or Christian, but sometimes when we need to take the patient for any procedure they still want to pray. We ask the patients to be quick. So, these are the times when we have difficulties.</p>
	Difference between Muslim and non-Muslim patients	<p>I think there is a big difference between taking care of Muslim and non-Muslim patients. For Muslim patients, there are prayers times, and at that time we have to delay any care given to them, but for non-Muslims we can do it any time, which I think makes a big difference.</p> <p>With non-Muslim patients, there are no prayer times, no fasting, no covering from head to toe or wearing dresses. These are the things that make the difference.</p>
Gender issues	Impact of gender on nurses’ workloads	<p>I had an old, male patient with me who was a religious person and he said he would not like a female nurse to touch him. In that case we had to find a male colleague to help us.</p>

	Male nurse	<p>I found not being able to carry out all of the care for the male patients quite difficult, because we have very few male staff and in order to get certain things done for male patients, you have to wait and wait and wait, because nobody is there to do it. I found that a little bit odd, but it is a religious thing and you just have to accept that.</p> <p>Sometimes the doctors are in hurry, but we have to wait to see the patient until she covers herself and allows us to come in.</p>
	Additional burden on female nurses	Regarding the female patients, there is sometimes the difficulty that I am always hesitant to enter a female patient's room, because it is against the culture here. So, I am not free in taking care of female patients, and am somewhat restricted.
Respect	Pressure to convert to Islam	<p>Generally the patient feels very happy with them, but some patients ask us questions like whether you are a Muslim, "you should be a Muslim." Sometimes also the patients give us booklets to read about Islam.</p> <p>I want to add something, to note that the patients are very curious about our religion here. Every time we go to a patient, he will ask us if we are Muslim, and they say that we should be Muslim.</p>
	Nurse complaints	Also, female patients always when I go in to their room, they ask me to cover my hair and why I am like this, like that, and so on.
	Male dominance	<p>The men here feel they are more powerful, and sometimes they are rude. They look at us in a bad way, and they do not understand that we are taking care of them. Like, a family will just say "I want to see the patient now" and we tell them that they cannot see the patient right now, because we are cleaning, and then they will go and talk to a male in the area because they do not trust us.</p> <p>Here I have also noticed that the doctors sometimes do not listen to us, and our suggestions have no value to them, which I think is due to the male dominance here.</p>
	Not respected because they are expatriate	Some patients think that we are just here to serve them, like their personal servants, and they throw things around the room everywhere and want us to "do this, do that, and clean that." Sometimes we have a feeling like we are servants here.

	Relationship between nurses and doctors	One thing I would like to add again is that we, as nurses, are not listened to here, especially by doctors.
	Hospital culture	In the UK, if we have a problem with patients, security will be called and they will see the case. Here, I think the patients are listened to more, and I have the general impression that I am being treated as a slave here.
Training and orientation	Limited training or orientation on Saudi culture	<p>So, the persons who come without orientation regarding the culture here just have a culture shock, and have difficulty adjusting and staying here for a long time.</p> <p>For us, there was a subject regarding multi-culture, but it was not specific to Muslims. We are living in a highly multicultural society and in general we were taught about different cultures and different people.</p> <p>No, I did not have any orientation regarding the culture, but I had Arabic classes where I learned how to read, write and speak Arabic.</p>
	Training by recruiting agencies and hospital	<p>I was not given any training here, but I had orientation with the recruiting agency through which I came here, who told me some basics about the culture and religion.</p> <p>During our general orientation, we were told only that patients here pray five times a day, also that we need to wear abaya when we go outside and some other simple things. However, they have not told us about how people think and how to deal with them</p>
	Arabic classes	<p>I want to have an Arabic class, but I think it would be nice just to have a conversational Arabic class. The class you take is much geared towards learning a language, like writing and reading, and that seems to me a very long way of getting know some of the words.</p> <p>I just wanted to speak to them, to get answers to my questions, but they do give us some pages, which, for the most part, are general and have nothing to do with nursing, but any words directly related with a medical context would be good.</p>
Self-learning and	Understanding	I learned a lot about the culture here from my



working experience	religion	<p>patients.</p> <p>I learned by myself, with my experience; I read books and I would ask my colleagues, and even patients, if I did not understand anything. In this way, I have learned a lot about the culture and other traditions here.</p>
	Learning from colleagues and friends	<p>My friends and my experience here in the unit where I am working.</p> <p>We learn a lot from our colleagues here; if I am unable to understand something in Arabic I will ask a ward clerk or other nurse who understands Arabic.</p>
	Learning from experience	<p>I started teaching myself through my day-to-day experience of taking care of patients here, and learning from my experiences with patients, their families, and my colleagues.</p> <p>I think orientation is not enough, and we learn a lot from our experience when we stay here and take care of a patient; that teaches us more than any orientation.</p> <p>In Saudi Arabia, we feel that the patients are our teachers and we have to learn a lot from them.</p>

### 3.11 Trustworthiness of Qualitative Data

The question of the reliability and validity of empirical studies was first addressed by proponents of positivism, so quantitative researchers. These researchers are suspicious of findings generated by qualitative researchers.

#### 3.11.1 Credibility (Internal Validity in Quantitative Research)

The roots of validity criteria originate from the positivist paradigm (see Section 3.3). Joppe (2000) defines validity as a measure of whether the results of a study are true, and do in fact measure what the researcher intended to measure. This subsection will discuss the measures of internal validity in quantitative research compared to credibility in qualitative research. Internal validity is described as the achievement of what is claimed by the research (Ray,

2003). Internal validity is used to measure the validity of results of quantitative research based on the research design and operational definitions used in the study (Giorgi & Giorgi, 2003). In phenomenological research, internal validity is measured according to a judgement of how confident the researcher is in their results (Polkinghorne, 1989). In other words, internal validity depends upon the credibility of the results. According to Lincoln and Guba (1985), credibility is the most important factor in establishing the trustworthiness of qualitative research. Credibility must be established, because qualitative methods in general, and phenomenological research in particular, affect the validity of results.

In order to promote confidence in and trustworthiness of the data obtained by this study, the researcher took several steps. Before data collection was initiated, and interviews with nurses and patients were conducted, the researcher became familiar with the general hospital targeted by the study, obtained relevant documents about the services provided, the types of nursing services available and the nationalities of nurses working for the hospital. The Nursing team and the Director of Research were very cooperative and friendly. No demands were made that would affect the cooperation with the hospital. Second, triangulation was used; triangulation refers to the use of more than one data source to ensure the credibility of results (Morse *et al.*, 2002). In this study, two data collection methods were used, interviews and focus groups. The interviews were conducted with patients and nurses while the focus groups were conducted with nurses only. In relation to triangulation, Guba and Linkoln (1994), stress that the use of different methods compensates for the shortcomings of individual methods, while also exploits the advantages of each method. This study did not rely solely on nurse views, but also recruited patients to take part in the study, which provided the opportunity to compare nurse views with patient views. Third, the researcher took steps to ensure honesty in nurses and patients, who were given the opportunity to decline participation in the study, and so were genuinely willing to give honest and frank information about their experiences of the hospital. I encouraged all participants to be frank and transparent. Fourth, probing was used to elicit detailed data. Nurses and patients were questioned iteratively using probes that encouraged them to honestly speak about their experience. Fifth, the researcher's prior experience of nursing was an important factor in understanding how to interact with patients and nurses. Patton (2002) stresses that the credibility of the researcher is important when conducting qualitative research because they are responsible for designing the research instrument, as well as collecting and analysing the

data. Working as a nurse in Saudi hospitals was an advantage for the researcher when collecting data.

### **3.11.2 Transferability (External Validity/Generalisation in Quantitative Research)**

In quantitative research methods, large samples are used to generalise the research results to the larger population. The results are usually based on a sample that is understood to represent the target population, resting on the assumption that the sample was properly drawn using probability sampling techniques such as simple random samples, where everyone in the population has the chance to be included in the sample, stratified sampling, where the population is divided into strata such as gender, age, occupation and so on, or another type of sampling (Frerichs, 2008). In cases where the sample is not drawn from a proper sampling frame and based on explicit sampling techniques, then the results of a study will not be generalisable to the wider population.

In relation to the credibility of qualitative research, Lincoln and Guba (1985) argue that it is the responsibility of the researcher to collect sufficient information about the phenomenon being investigated. On this point, the researcher believes that sufficient information was collected to address the research objectives, as an adequate number of focus groups and interviews with nurses and interviews with patients were conducted. Readers and other researchers can therefore rely on the results and can be confident in transferring the research conclusions to other situations. Furthermore, the introductory chapter and literature review chapter of the present study have described the research problem and the phenomenon of non-Muslim nurses' views of caring for Muslim patients. This will enable researchers and readers to understand what is achieved in this study, and thereby enable them to compare examples from the present research to other settings (Babour, 1998). In order to transfer the results of this study to other contexts, the researcher ensured that the hospital placed no restrictions on interviewing patients and nurses, and obtaining detailed information.

### **3.11.3 Dependability (Reliability in Quantitative Research)**

The reliability of quantitative research is measured by how an instrument, such as a questionnaire, is completed and scored by two or more people (Innes & Straker, 1999). In survey research, for example, the concern is for consistency of measurement and agreement among research participants (Brown, 1997). In other words, reliability refers to the degree of consistency or dependability with which an instrument measures what it is supposed or

designed to measure (Joppe, 2000). Joppe (2001: 41) further states that reliability "... is the idea of reliability and repeatability of results or observation."

Kirk and Miller (1986) identify three types of reliability in quantitative research: the degree to which a measurement can be repeated but remains the same; the stability of the measurement over time; and, the similarity of measurement within a given period of time.

Lincoln and Guba (1985) stress that in order to enable researchers and readers to repeat a particular study, it is imperative to report all of the steps taken in the research. Therefore, in order to ensure the repeatability of the results of this study, the research design used, phenomenology, was described in detail, and compared with other possible designs, such as ethnography and grounded theory. The use of qualitative research rather than quantitative research was also justified, and the data collection methods, focus groups and interviews, as well as the data analysis strategy, the constant comparative approach, have also been detailed.

#### **3.11.4 Confirmability (Objectivity in Quantitative Research)**

As mentioned earlier in this chapter, quantitative research methods are described as being realist and objective, whilst qualitative methods are viewed as subjective. These descriptions reveal that a realist focus is on discovering existing realities, where the role of the researcher is to use objective research methods to discover the truth. Therefore, the researcher's role is minimised, increasing the importance of objectivity. However, it is difficult to completely measure objectivity (Creswell, 1994). Patton (2002) claims that even where quantitative researchers design their questionnaires and test their results, bias is inevitable, and thereby it is difficult to ensure true objectivity.

On the other hand, in qualitative research, the focus is on subjectivity, whereby participants play a greater role in the research process (Creswell, 1994). The emphasis on subjectivity in qualitative research confirms that the results of a study depend on the participants rather than the researcher. Confirmability in qualitative research is therefore comparable with objectivity in quantitative research; confirmability requires that research findings result from participant experiences and ideas, rather than from the preferences of researchers. As mentioned above, triangulation involves using more than one research method, something that promotes confirmability (Miles & Huberman, 1994). As mentioned earlier in this section, triangulation was achieved in this study, through the combined use of focus groups and interviews, proving that the attention and intention was on patient and nurse views rather than on the perspective

of the researcher. The data collection methods used in this study has also been described in detail to enable researchers to understand the basis on which the results were generated.

### **3.11.5 Reflexivity**

Reflexivity is regarded as one of the main determinants influencing the trustworthiness of qualitative results. Finlay (2002) stresses that enhancement of data trustworthiness requires researchers to understand his/her role in the study being done. The role of the researcher in a study should be acknowledged in data analysis, writing up and documentation of the research process. According to Ballinger (2006), the role of a researcher should be consistent with the research methodology of the study under investigation. As a researcher, I was transparent and ethical during the course of my study. I was not relativist in my research since my presence and position were not existed apart from writing and interpreting the results. I have literally followed up the phenomenological research approached used in this study.

In this study, focused mainly on non-Muslim nurses' and Muslim patients' views and my role were restricted to interpretation of data. For this reason, I indulged myself in the data through reading the transcripts line-by-line as well as used advanced and sophisticated data analysis technique such as constant comparative approach which allowed me to compare different nurses' views with patients' views. Using thematic analysis also enabled me to come up with main themes and sub-themes which were used in writing up the results and interpretation of different perspectives.

### **3.12 Ethical Framework and Ethical Considerations**

Using a phenomenological method requires the researcher to pay attention to ethical issues, which should be taken into consideration throughout the research process (Orb *et al.*, 2001). For this reason, the researcher considered potential ethical issues in all stages of the research, including research design, data collection and data analysis. The main purpose of this is to ensure the transparency and quality of the study. Prior to any researcher's engagement in health and nursing research, they must consider the social and cultural values of patients and nurses. A researcher also should situate their study within the appropriate ethical framework

(Harrowing *et al.*, 2010). The ethical framework of the present study consisted of ethical approval from the University, preparation of an introductory package about the study, consenting to participation in the study, assurances of anonymity, privacy, and the confidentiality of collected data.

### **3.12.1 Ethical Approval**

Before conducting the pilot study and recruiting nurses and patients, ethical approval from the School of Nursing and Midwifery was obtained. This confirms the researcher's commitment to research ethics, requiring that participant privacy and confidentiality of data is respected.

There was an ethical procedure that needed to be followed. First of all, the ethical approval form was obtained from the school office. Each point was carefully read and understood. The form was then completed, signed and sent to the research supervisor to sign. Finally, it was also signed by the Head of the School of Nursing and Midwifery. This process took about two weeks. A letter from the School of Nursing directed to the general hospital in Saudi Arabia was also obtained. This letter consisted of information about the research objectives, asking the hospital to assist in recruiting nurses and patients to participate in data collection. Once the Director of Nursing Practice and Research and the Director of Research Affairs received the letter from the School of Nursing and Midwifery, DeMonfort University, they invited the Research Committee to discuss the letter and the proposed data collection. After two weeks, a formal letter from the Director of Research was received, informed the researcher that the committee had approved the proposal and consented to data collection in the hospital (see Appendix 2).

### **3.12.2 Introductory Letter and Information Package**

An information package about the study was prepared, which included a number of items such as: the study objectives; rationale; a request for potential participants to take part in the study, which was entirely voluntarily; procedures for moderating focus groups and conducting interviews; time allocated for focus groups and interviews; an explanation of privacy procedures and confidentiality of data. The letter also included information about enquiries and questions concerning the procedures of data collection, offering the researcher's address in Saudi Arabia, the address of the School of Nursing and Midwifery, University of DeMonfort, and landline and mobile phone numbers for the researcher. It was

indicated in the letter that the data would not be used for any purpose other than the study. Potential participants were also informed that an ethical approval letter from the University and the general hospital in the City of Riyadh had been obtained. Participants were assured that the collected data would be confidential and would not be used for any purpose apart from the study. The researcher committed to respect the privacy of participants in all aspects of the study.

### **3.12.3 Consenting to Participation in the Study**

Obtaining informed consent entails providing sufficient information about the research, ensuring that there is no explicit or implicit coercion, so that potential participants can make an informed and free decision to take part in the research. Before signing the consent forms with nurses in the focus groups and interviews, the research objectives and its benefits were explained to nurses and patients, as well as how relevant issues would be addressed by the hospital. Nurses and patients were provided with essential information in written form, which allowed them to make an informed choice to participate in the study. Where some patients were illiterate, the researcher spoke to their relatives and obtained verbal consent in the presence of their relatives, for example sons and wives. Nachmias and Nachmias (2000) emphasise that gaining the informed consent of participants reduces the legal responsibility of participants and researchers. For this reason, nurse and patient participation in the study was voluntary. In addition, the acquisition of informed consent in this study allowed nurses and patients the freedom and self-determination to participate in the study.

### **3.12.4 Anonymity**

Anonymity of data means that the data collected, manipulated and written about should be anonymous. Anonymity initially means that the names and addresses of participants are removed (Jordi & Herran 2010). Nurses and patients in this study were informed that their names would not appear on any information sheets, apart from the consent form, which would be secured in a private research cupboard. Anonymity of information was taken into consideration at all stages of this study (Field & Morse, 1992) including transcription, data analysis and coding, as well as when writing up the results.

### **3.12.5 Privacy**

Privacy indicates a domain of information specified by society and culture (Porter, 1998). This study respected the background characteristics of nurses and patients, and did not intrude on their private and personal life by asking for further information. When moderating the focus groups, the focus was only on asking questions related to the research, regarding patient and nurse experiences in the hospital.

### **3.12.6 Confidentiality of Collected Data**

Confidentiality refers to the disclosure of information under any conditions aside from the research purposes (Porter, 1998). Nurses and patients were informed that data would be stored in a secured cabinet in the researcher's home, and that no one else would have access. It was also confirmed that the computer files would be secured with a user name and password. The researcher endeavours not to breach the confidentiality of data and ensure the protection of data both during and beyond the completion of the study. Participants were told that if they felt that confidentiality had been broken, they were free to cease the interview and withdraw from the study.

## **3.13 Conclusions**

The main aim of this chapter was to present and discuss the research design and methodology used to achieve the study objectives. This study used the phenomenological approach, and justified this selection through comparison with other research methods, such as grounded theory and ethnography. It was also beneficial to understand the difference between quantitative and qualitative research methods, since the former follows the positivist paradigm while the latter follows the interpretivist paradigm.

The research objectives were achieved using the phenomenological approach and two methods of data collection, namely focus groups and interviews. The first research question pertained to non-Muslim nurses caring for Muslim patients; to achieve this objective, both focus group discussion and interview methods were used. The second question concerned patient views, and was answered using interviews. The third research objective was satisfied using focus groups, interviews with nurses, and interviews conducted with patients.



## **CHAPTER FOUR: FINDINGS**

### **4.1 Introduction**

This study has taken a hermeneutic phenomenological approach to reveal the experiences of non-Muslim nurses caring for Muslim patients in Saudi Arabia. It has employed an interpretive approach in order to understand the care relationship from the viewpoint of the nurses and gain an insight into their experiences. The nurses have been encouraged to speak freely, and in depth, thus enabling the researcher to gain rich insights into a number of aspects of the care relationship, including religion, culture and language. Moreover, the nurses also revealed the ways in which such factors impact on their provision of care.

This chapter presents the findings of the semi-structured interviews and focus group discussions conducted with the nurses. It is structured according to the themes that emerged through the analysis of the transcripts. The interviews and focus groups were designed to include questions reflecting the research objectives and questions, including those on the three main areas of religion, culture and language. The semi-structured interview technique was adopted in order to gain a deeper insight into the experiences of the nurses and due to the fact that it permitted the research to control the discourse.

The findings reveal a number of themes emerging from the nurses' experience of caring for Muslims in an Islamic country. Both religion and Saudi culture featured significantly, with the two often being confused by the nurses. The themes included a defence of the professionalism of the nurses in caring for Muslim patients regardless of their religion, and the inability to carry out nursing duties (or being busier than necessary) due to religious and cultural factors and language barriers. Moreover, a significant part of their experience concerned the fact that they felt they were not respected as non-Muslims, non-Saudis, as well as women and as nurses. Finally, insufficient training and development had a significant impact on their experience, meaning that they needed to depend on others (and their own experience) to develop themselves as nurses and to provide congruent care.

### **4.2 Profile of the nurses (participants)**

This section presents the profile of the non-Muslim nurses in this study. Table 3 represents the distribution of all 20 participants. Information is also included concerning the following: (1) the gender of the nurses; (2) number of years working in Saudi Arabia; (3) their country

of origin; (4) qualifications; (5) countries where they have previously been employed (Tables 3 and 4). The themes were extracted from the interviews and focus groups conducted with both nurses and patients (see 3.12 Data Analysis Strategy).

**Table 3: Distribution of nurses**

Method of data collection	Number of participants
Semi-structured interviews	8
Focus groups	3 focus groups * 4 = 12
Total participants	20

**Table 4: Nurses' profiles (interviews)**

Nurse	No. Years In Saudi Arabia	Gender	Country of Origin	Nursing Qualification	Previous Experience (country)
Nurse 1	3	F	South Africa	Bachelor Degree	USA
Nurse 2	7 months	F	Australia	Vocational	Australia
Nurse 3	10	F	USA	Bachelor Degree	Japan & USA
Nurse 4	8.5	M	United Kingdom	Bachelor	United

				Degree	Kingdom
Nurse 5	5	F	Sweden	Bachelor Degree	Sweden
Nurse 6	2	F	United Kingdom	Bachelor Degree	United Kingdom
Nurse 7	4	F	Philippines	Bachelor Degree	Philippines
Nurse 8	3.5	F	Philippines	Bachelor Degree	Philippines

**Table 5: Nurses' profiles (focus groups)**

<b>Focus Group 1</b>	<b>No. Years in Saudi Arabia</b>	<b>Gender</b>	<b>Country of Origin</b>	<b>Nursing Qualification</b>	<b>Previous Experience (country)</b>
Nurse 1	3	M	Philippines	Diploma	Philippines
Nurse 2	21	F	India	Diploma	India
Nurse 3	3	F	Philippines	Diploma	Philippines
Nurse 4	6	F	Philippines	Diploma	Philippines
<b>Focus Group 2</b>					
Nurse 1	27	F	Philippines	Diploma	Philippines
Nurse 2	10	F	Philippines	Bachelor Degree	Philippines
Nurse 3	5	M	Philippines	Bachelor Degree	United Kingdom &

					Philippines
Nurse 4	7	F	Lebanon	Bachelor Degree	Lebanon
Focus Group 3					
Nurse 1	7	F	South Africa	Bachelor Degree	South Africa
Nurse 2	2	F	Ireland	Bachelor Degree	United Kingdom, Ireland & Australia
Nurse 3	1	F	Philippines	Bachelor Degree	Philippines
Nurse 4	4	F	United Kingdom	Bachelor Degree	United Kingdom

#### 4.2.1 Years of experience of nursing staff in caring for Muslim patients

Participants in this study were asked about their previous length of experience in caring for Muslim patients in Saudi Arabia. The main purpose of this question was to compare the length of participants' working experience with their experience of caring for Muslim patients. It was found that experience ranged between 1 and 27 years.

**Table 6: Themes and sub-themes of the experience of non-Muslim nurses caring for Muslim patients in Saudi Arabia**

Theme	Sub Theme
Understanding Islam and Religious Congruency	<ul style="list-style-type: none"> <li>Understanding Islam</li> <li>Providing Religiously Congruent Care</li> </ul>
I am a professional (Defence of Professionalism)	

<b>I cannot do my job</b>	<ul style="list-style-type: none"> <li>• <b>Religious Barriers</b></li> <li>• <b>People around the Patient</b></li> <li>• <b>Fear of Transgression and False Accusation</b></li> <li>• <b>Language Barriers</b></li> </ul>
<b>Busy Nurse (workload and scheduling)</b>	<ul style="list-style-type: none"> <li>• <b>Prayer, Fasting and Ramadan</b></li> <li>• <b>Gender</b></li> <li>• <b>Lack of Translation Services</b></li> </ul>
<b>Not Respected</b>	<ul style="list-style-type: none"> <li>• <b>I am a Female, Expatriate non-Muslim Nurse</b></li> <li>• <b>The Institution</b></li> </ul>
<b>Inadequately Trained</b>	<ul style="list-style-type: none"> <li>• <b>Training and Orientation</b></li> <li>• <b>Dependency on Self Learning, Working Experience and Colleagues</b></li> </ul>

### **4.3 Understanding Islam and religious congruence**

There was a clear indication in the findings that, both from the answer to the questions and the manner in which they provided care, the nurses understood some aspects of Islam. However, there was stronger evidence to support the fact that there were many aspects of Islam the nurses did not understand, or that they confused certain patient behaviour with culture. Nevertheless, there was evidence that they understood religious practices to a certain extent, or had made an effort to learn (or at least respect) such practices, in order to provide religiously congruent care. The findings revealed that such understanding was reflected in the nurses' actual ability to provide religiously congruent care. However, this appeared to be limited to using religious words and, to a certain extent, facilitating ablution.

#### **4.3.1 Understanding Islam**

Understanding of Islam was expressed in terms of understanding that religion is important to the patients and thus should be respected, rather than understanding religious practices. Although the nurses may not have agreed with certain Islamic practices (such as fasting when patients were on medication) they did show a level of understanding of such practices, or at least made an effort to respect them, as the following response demonstrates:

*Another thing that was not understandable to me was that we were not allowed to eat in front of patients during Ramadan, which I think was hard for me to accept because sometimes we were really feeling hungry or thirsty but we could not eat or drink because it was Ramadan. Because of this, I mainly requested leave during Ramadan. I was not supposed even to chew gum in front of patients, as my head nurse told me not to do this. Even in the dining room, I was supposed to close the door before I ate. So now I have tried to convince myself that I am in a Muslim country and I should respect the laws or traditions followed if I want to stay here. In this way, I have overcome such kinds of issues. (FG3 N5)*

This idea of respect is reiterated in the following statements:

*I respect prayer. You know when it is prayer time, and you should respect prayer time. (FG3 N1)*

And:

*We were told some basic things about Muslim patients, such as we should respect prayer times, and when patients are praying we should wait to give them any treatment until they finish their prayer. Also we should not eat in front of patients in Ramadan and things like that. (FG3 N4)*

However, a factor arising from the nurses' experience, was confusion between religion and culture. Nurses frequently attributed aspects of their experience to culture, when it was, in fact, due to religion, or there was complete acknowledgement that they understood the difference. Nevertheless, this has highlighted the fact that there were issues that needed to be addressed relating to the differences between religion and culture, particularly since this study has been focussing on the issue of religion related to the nurses' experience of care.

There were a large number of statements demonstrating that nurses did not know the difference (or did not distinguish between) religion and culture. The following statement represents an example of this:

*So, I think here patients are sometimes kept unaware of their true situation or medical condition. I do not understand if this is related to religion or culture, that the patient's families do not want the patients to know their real condition. (FG3 N4)*

The following statement clearly demonstrates this nurse's confusion of religion and culture:

*Some patients are sitting on the floor, which I think is their culture, but is not medically good for patients. So I think sometimes religion affects their care (FG2 N4)*

In reference to understanding the differences between religion and culture, there were a number of nurses who acknowledged that they knew the difference. One nurse said:

*When I came here, things were wholly different, because there is something that is related to culture and not to religion, which we can only learn when we are in that environment. We do not get much information about different cultures and religions during our studies (Nurse 1).*

As well as this confusion between religion and culture, a number of the nurses were not certain if particular practices were associated with religion. This is illustrated in the following statement:

*I noticed another thing here is that the patients are kept for very long periods on ventilators, sometimes even 3-4 years. Even patients who are brain dead are still kept on ventilators, I do not understand why this is done here. It may be because of religion. (FG3 N2)*

Moreover, there was evidence that the nurses did not understand the religious sensitivities of the patients. The following anecdote clearly demonstrates that, although the nurse had clearly good intentions about the patients' health, she did not understand the severity of her actions in relation to religion:

*When I came to Saudi Arabia it was in 2009. I had a patient who was 65 years old or thereabout. He had a very long beard, and he was intubated. The patient was going to be given a tracheostomy because he had been intubated for too many days, and the beard was in the way of neck. He was a Muttawa, a religious policeman in Saudi Arabia who cares that everybody has to follow the rules of Islam. He was sick. He had 10 sons and only one son was not a Muttawa, the others were all Muttawa. I asked his son through a translator if I could shave his beard because it was not hygienic and it was in the middle of the tracheostomy and therefore could cause him infections and many problem, He said no problem: "Maafi Mushkala." So the translator told me that I could go ahead and shave the patient, so I shaved him like a baby. The next day when the women from the family came, they were crying as if I had killed him and he would not live anymore. Everybody in my department was saying "you are going to be fired, you will face many problems". I was shocked, because all I had done*

*was shaving him and because, you know, in our country it is not a big deal and had he not been shaved then it would have been a big problem because it is unhygienic. The women were crying and my head nurse came and asked what I had done. I explained that I simply shaved the patient's beard, and my head nurse asked why I had done so. I said "because he is going to have tracheostomy". She said "you should not do that" and I replied "I am sorry, because I did not know". So, this means that you should not touch the face of a man here, because it means a lot to them. (Nurse 6)*

#### **4.3.2 Providing religiously congruent care**

It has already been demonstrated that religion has both a positive and negative impact on care (McGee, 1994). One area where nurses expressed a willingness to engage in a religious practice was related to the use of religious phrases and supplications. All of the nurses felt that this had a positive effect on care, and none indicated that they were reluctant to use Islamic supplications, even though they themselves were non-Muslim.

It was clear from the semi-structured interviews and the focus group discussions that the non-Muslim nurses understood that Saudi Muslim patients appreciated and praised nurses when they used phrases such as 'Bismillah' ('In the name of Allah') or 'Alhamdulillah' ('all praise is for Allah'). The nurses recognised the importance of religious phrases to patients, and that these words benefitted the patient in terms of pain relief and made them feel more comfortable:

*When we use 'Bismillah' we feel comfortable with the patients and the patients also develop more trust for us and if we sometimes forget to say this, and the patients are in pain, they will tell us they have the pain because we did not say 'Bismillah'. I believe, both religion and culture have great effect on patients' care. (FG2 N2)*

And

*I think using these words, for example 'Bismillah', makes the patients feel more comfortable. (Nurse 3)*

And

*The patient feels good when we use these words. They feel good when I say 'Bismillah' (Nurse 6)*



The nurses used these words in relation to their provision of care. For example, if a nurse was giving an injection she would say 'Bismillah' because it had been requested to do so by their patient. However, evidence of their willingness to use these words went beyond mere compliance, as some nurses asked the patients to use these words.

In the nurses' experience it was clear that they felt that religious phrases not only benefitted the patients, but, to some extent, themselves. The following conversation occurred between the researcher and one of the nurses:

**Researcher:** *What do you think about saying 'Bismillah'?*

**Participant:** *I use 'Bismillah' just before giving an injection. I adopted this word from my senior. I had one patient who asked me "why do you say 'Bismillah'? Are you a Muslim?" I told him no, but I just use this to feel good.*

**Researcher:** *When you use 'Bismillah', do you feel the patient seems more relaxed?*

**Participant:** *When I want to give an injection to a patient, I ask the patient to say 'Bismillah' and they feel good about this. (Nurse 8)*

The willingness to use Islamic phrases or supplications reflected the overall respect of the nurses for the patients' religion, and that they did not view Islam as an issue. Although there were some patients who felt that the nurses were not fully committed to saying religious words when administering care, most were satisfied. For example, one patient said:

**Researcher:** *do you feel comfortable when she says 'Bismillah'?*

**Patient:** *yes, I feel comfortable (Patient 5)*

Moreover, patients generally did not mind non-Muslim nurses using religious phrases:

**Researcher:** *so, when the nurse comes to inject you, does she say 'Bismillah'?*

**Patient:** *yes, all of them use 'Bismillah'.*

**Researcher:** *do you feel comfortable?*

**Patient:** *yes I feel comfortable, even the Americans use 'Bismillah'.*

**Researcher:** *and you feel comfortable with this?*

**Patient:** yes, Alhamdulillah, they are mentioning Allah when they touch anything (Patient 4)

#### **4.4 I am a professional (defence of professionalism)**

The majority of the nurses emphasised that religion had no detrimental impact on the standard of care, and that it was not considered to be an issue. The patients' religion was, to some extent, seen as irrelevant, as the following statements reveal:

*I do not judge patients based on their religion or culture, but I judge the patients based on their personalities and how their behaviour is towards me. So, there is nothing specific that can be said about patients of any religion. There are good and bad individuals in every religion, so I generally do not make my impression of patients from their religion. (Nurse 4)*

And

*It does not really make any difference to me. I have no particular feelings whether the patients are Muslims, or of any other religion. It doesn't bother me. (Nurse 2)*

The issue of the religion of the patient being irrelevant in terms of the ability to provide care was strongly manifest in the nurses' defence of their professionalism. The majority of the nurses felt that they needed to defend their professionalism with respect to caring for Muslim patients, and they felt that such professionalism was sufficient for them to provide care regardless of the faith of the patients. Nurse 6 stated:

*This does not matter when you are providing care. You have to give the best care as a professional nurse. You only have to consider that they have all the things they need for their religious duties, but the religion does not affect the kind of care you give to patients. You cannot say that one cannot take care of Muslim patients, because it does not make any sense. (Nurse 6)*

It was clear that the nurses felt that, as professionals, they should provide nursing care equally, regardless of the patients' religion. The issue of professionalism (or the defence of professionalism) was very important to the nurses:

*I agree that the religion of the patients does not affect the level of care we provide to a patient. We simply take care of patients of every religion in a professional way, so level of care is the same for all patients, whether Muslims or non-Muslims. (FC1 N3)*

The above statements are supported by a nurse participating in one of the focus groups:

*I do not think that there is a difference in care if the patient is Muslim or not. It does not affect me whether the patient is Muslim or not. I just know how to take professional care of my patients, regardless of their religion or any other criteria. (FG1 N1)*

Throughout the nurses' experiences, there were a number of issues affecting their working practices that were related to religion and culture. Although they recognised this, they still defended their ability to provide care, as the following statement demonstrates:

*I have been here a long time taking care of patients, and if my nursing was affected, I would not have been here for such a long period. Although we come across many issues, like the ones we told you about earlier, these do not interfere with our nursing care. So, I think religion does not affect the care of patients. (FG3 N2)*

The patients also supported the idea that, as long as a nurse is professional and does her job well, then issues such as faith should have no bearing on the quality of care. When expressing their opinions, patients specified the issue of equality and professionalism, putting forward the point that first and foremost nurses take care of them as professionals, and thus they receive a good standard of care, regardless of the issue of religion. The expression of professionalism over religion was even stronger amongst patients than it was amongst nurses, thus confirming the nurses' opinions. There remained a defence of professionalism over the issue of religion in the nurse-patient relationship, despite the fact that the nurses were referring to the religion of the patient, while the patient was referring to the fact that the nurse was not Muslim. The following are a selection of the large number of statements demonstrating the views of patients concerning the importance of professionalism over the religion of the nurses:

*Even if he is non-Muslim and well-qualified I prefer him to work with me more than an Arabic one, I can say nothing if there is no one else. (Patient 2)*

*Everyone should behave honourably in his work, regardless of religion; a person satisfies himself in work and performs it perfectly. (Patient 3)*

*If a Saudi nurse does not reach the required level, I would not prefer her. I mean that if the Saudi isn't sincere in her work I cannot favour her. (Patient 7)*

*Religion is important for me, but also it is important to have a good service. If the work of the nurse is good, there is no problem if she is a Muslim or a Christian. (Patient 7.*

*I don't think that being a Muslim or a Christian would affect her; moreover, non-Muslims deal in a good manner with patients. (Patient 6)*

Further evidence that a nurse's professionalism was more important than their religion, was the fact that patients often made comparisons between non-Muslim nurses and Saudi nurses (who are Muslims), in terms of their professionalism, mostly favouring non-Muslim nurses. These comparisons were in addition to the general praise that patients gave non-Muslim nurses for being more professional.

Furthermore, the interviews revealed that there was a consensus among patients that non-Muslim nurses (being expatriate nurses) were more professional and had more experience than local Saudi nurses. In making a comparison between Saudi and foreign nurses a patient said:

*When working, it may be that the foreigner is a little better than the Saudi. Foreign nurses may be more familiar with this work, so their skills are better. (Patient 1)*

In their comparisons, some patients even made some criticisms of the professional capabilities of the Saudi nurses, as the following statements illustrates:

*You feel that the Saudi nurse is hesitant and not confident in herself and she always asks her colleagues. But the foreigners are more confident in themselves and in what they are doing. (Patient 5)*

*The foreign nurses have more experience and practice. I mean, even when a Saudi comes to me to do an injection, I don't feel comfortable, unlike with the foreigners, because she comes quickly to perform her duty. (Patient 5)*

*Yes, from the perspective that she is more polite and the medicines arrive on time, and she is organised, even in arranging the bed. Therefore, I see that she is better. (Patient 5)*

However, although the patients agreed with this view of the nurses' professionalism, they later admitted that a Saudi or Muslim nurse might be better at providing religiously congruent care, providing they were equally professional as the non-Muslim nurses. Upon further probing, the issue of religion began to arise. Hence, religion can be seen to have significance

for the patient. This is mainly due to the fact that Muslim nurses may be more sensitive to the needs of Muslim patient. These needs, however, were not related directly to nursing care generally (i.e. professionalism) but instead were spiritual needs and a recognition of religious practices, such as ablution. However, this was in no way a reflection by the patients on how they felt about the more professional capabilities of the non-Muslim nurses.

The following interviews illustrate the fact that if non-Muslim and Muslim nurses were at the same standard professionally, Muslim patient preferred a Muslim nurse, as they were better at providing for spiritual needs:

**Patient:** *I prefer Muslims.*

**Researcher:** *you feel more comfortable with a Muslim?*

**Patient:** *surely.*

**Researcher:** *why?*

**Patient:** *because she considers religion in her work and dealings.*

**Researcher:** *when she is non-Muslim, does this affect her work with you?*

**Patient:** *yes, it affects me. But what can I do?*

**Researcher:** *from which aspect does it affect you?*

**Patient:** *because the Muslim is closer and more merciful to me.*

**Researcher:** *you mean that the foreigner has no mercy?*

**Patient:** *the foreigners do not neglect their work in taking care of their patients; it's just they don't understand our spiritual needs. (Patient 8)*

And

**Patient:** *I feel more comfortable with Filipinos and Saudis, particularly with Saudis, because they understand my speech and they have mercy. (Patient 7)*

And

**Patient:** *of course, I prefer the Saudi one.*

**Researcher:** *why you prefer the Saudi one?*

**Patient:** *I prefer her because of her religion and because she understands I and I understand her. (Patient 7)*

The idea above was also expressed in relation to practical religious needs:

**Patient's companion:** *but when unclothed, I think the Muslim is better, because she knows about cleaning you better for prayer. The foreign nurse can clean you, but not like a Muslim.*

**Researcher:** *do you mean Wudu? (Ablution)*

**Patient's companion:** *yes, the patient requires cleaning because she must pray, and in our religion cleanliness is important. The Muslim nurses understand about ablution and prayer. (Companion of Patient 7)*

This idea, specifically in relation to the idea of ablution, was also expressed by the following patient:

**Researcher:** *you mean that you trust the Muslim?*

**Patient:** *yes, because she knows our traditions.*

And

**Patient:** *A non-Muslim can clean, but I think that a Muslim has more understanding of Wadu than a non-Muslim. (Patient 6)*

The patients were clearly concerned about nurses understanding their religious practices, and felt that the non-Muslim nurses would not be able to facilitate their observance properly as they did not understand religious requirements. There was also a shared opinion that nurses should understand such religious requirements before arriving in the country.

#### **4.5 I cannot do my job**

The findings demonstrate that aspects of religion and culture in Saudi Arabia were a significant impediment to the nurses' ability to carry out their care duties. All the nurses in the study expressed this.

#### **4.5.1 Religious barriers (including gender, fasting, prayer, covering, modesty and physical contact)**

In the nurses' experience, prayer had an effect on care, and this was an aspect that concerned all the non-Muslim nurses in this study. There were different ways that prayer affected care. This included interfering with the timing of the administration of medicine, delaying important procedures and changing the working routine of nurses. One of the nurses in the semi-structured interviews remarked:

*Certainly, there are prayer times. When we first got here, we were told that you have to stop doing important care because people want to pray. Initially, I found this somewhat difficult, because surely your health and being alive is more important than absolutely having to say prayers right now? (Nurse 2)*

Another example of where a nurse felt that prayer interfered with care was the following:

*It was really difficult for me to adjust to taking care of patients here. We have to wait to give the patients medication or treatment, because sometimes when you go inside their room they are sleeping or praying. (FG1 N2)*

Another nurse felt that fasting could affect a patient's individual treatment plan. There was also a consensus among the nurses that it was unnecessary for a patient to fast if they were ill:

*I found that here people are practicing Muslims. I know that in Islam if you are a patient and very sick, you are excused the necessity to fast in Ramadan, but I found that most of patients, even they are sick, still do the fasting every day. (Nurse 7)*

Muslim females are required to wear the hijab, which covers all parts of the body, including the hair. The nurses provided a large number of examples concerning the issue of women having to cover up in front of men, which they felt had an unnecessary impact on their ability to provide care. The reason the nurses felt this was unnecessary was because they themselves were female. However, female patients did not want to risk being seen without the hijab by male medical staff. The following statement shows how covering directly affected patient care:

*I work in Oncology, taking care of patients receiving chemotherapy. The only problem I encountered is with female patients. If they are covered when they are on the bed we cannot see if the patient is cyanotic, because they are wearing an abaya. (FC2 N1)*

The nurses felt that in their experience of caring for Muslim patients covering became an irritation. One nurse noted the following:

*We have female patients here, and when we take them for an x-ray or CT scan, before the doctor or technician comes to give them the procedure, we need to inform the female patients that a male is arriving, so they can cover their faces. If we do not tell them in advance, sometimes they are not happy and are angry that we did not tell them (FC3 N3)*

The male nurses in this study also had an issue with females covering themselves, stating that it seriously interfered with the care that needed to be provided. One male nurse (who worked in the emergency room) stated the following:

*I wonder why the females here are always covering themselves, even in the Emergency Room. I had a patient who had an allergy, and I want to see what kind of allergy it was. I was new here and did not understand the culture, and when I uncovered her face to see her, she started shouting and screaming about the fact that I had uncovered her face. I had to contact Patient Relations, and they intervened. (FG2 N3)*

Physical contact with patients was a further issue that the nurses felt impeded their ability to provide care. The female nurses were very conscious about physical contact with male patients: they were aware of the discomfort it would cause their patients as well as their own discomfort. The following statement clearly illustrates this:

*As a female nurse, they were giving me male patients to work with. For example, if I have to clean a male patient, it is really very difficult and embarrassing for me, and also for the patient. Sometimes, I have to clean the private areas of male patients as well. (FG2 N4)*

The following statements illustrate the fact that nurses felt that the patients themselves were uncomfortable with female nurses, and there was some indication by the nurses that this was related to religion:

*The male patients also are very strict, although they do now sometimes allow you to touch them. One of my patients was an old man, who was religious, and he said he did not like a female nurse to touch him. (FG2 N1)*



Evidence that the nurses felt that the patient's refusal or dislike of being touched was a hindrance to health is illustrated in the following statement:

*Sometimes, if the patients are not clean, they say they are clean and refuse to be cleaned. I think is because maybe they are not comfortable with female nurses cleaning them. (FG2 N4)*

The study found that the nurses were very conscious about physical contact (particularly inappropriate physical contact), and were aware that this was very much an issue in Saudi Arabia. They frequently made comparisons with their previous experiences in the West. There was also concern about accidental physical contact, which was considered inappropriate in Saudi Arabia and could lead to patients being upset. Nurses therefore had to be mindful of this at all times:

*I feel one thing here that is really difficult is the distance between the genders. It is really one thing that takes a lot of getting used to. This is not the same as in the West, as there men and women are together. We can shake hands, we can hug each other and touch one another. Here, I think we have to be mindful of just avoiding all these kind of things and especially touching some of them, who sometimes become very annoyed, even if it was done accidentally. (Nurse 1)*

Another nurse said:

*Regarding the culture: I had one patient whom I touched with my hand in order to insert a line. I was palpating the veins, but the patient's sitter told me to wear gloves on my hands because he said "our culture does not allow a female to touch a male". So therefore I should wear gloves. (Nurse 5)*

The findings reveal that the nurses were clearly perplexed by the idea that touching was an issue, and they often expressed a view that this was ridiculous situation for a nurse caring for a patient.

#### **4.5.2 People around the patient**

The patients' families had an impact on the nurses' ability to care for patients. Families in Saudi Arabia are involved in all aspects of a family member's life, including health and healthcare. The semi-structured interviews with nurses indicated that the nurses felt kinship

frequently interfered with patient care. Moreover, patients' families had additional authority, because physicians and nurses usually discussed important issues with family members rather than with their patients. This study highlighted the fact that the influence of the family seriously impacted on the care provided by the nurses. This influence manifested itself in different ways, including controlling information between nurse and patient, or controlling or changing the care itself (i.e. controlling the medicine or care regimen of the patient and physically getting in the way). The following statement clearly demonstrates the influence of families:

*I work in Orthopaedics, where we try to make the patients independent. But I noticed that here, when we have such a patient and we are trying to make him independent, his family is there and they just want the patient to rest in a wheelchair, or on bed, and they do everything for the patient. This makes it difficult for a patient to become independently mobile. (FG3 N4)*

It was clear that the nurses felt that patients' families were a barrier between themselves and the patient, which impeded care. Specifically in relation to controlling information, one of the nurses stated:

*When it comes to communication with the family, I think sometimes we face difficulties regarding the patient's families or sitters interfering with our care. They sometimes refuse the things we want to do, and I think this is due to these procedures not being well explained or interpreted to them in order to clarify the way we want to do things. (Nurse 4)*

Another nurse expressed her views about the physical interference of family members with regards to patient care. She felt that there too were many family members around the patient, and stated the following:

*When any Muslim patient is admitted, the whole family will be there around him. Sometimes, only one patient has an appointment, but the whole family accompanies him to see the doctor. This makes the areas very crowded, because sometimes there is a little space just for patients and it is too crowded. (FG3 N2)*

This view was supported by a nurse in the same focus group, who provided more detail about the implications of having too many family members around the patient:

*With this, the patient's care is also affected. When there are too many people surrounding a patient, there is always a risk of infection for the patient. Also, it means we cannot maintain*

*hygienic conditions for the patients, because the people around them throw their things everywhere, which makes the situation even worse. These also compromise patient safety. When there are things on floor (and especially water on the floor) the patients can have falls. Also, we have slips and falls many times with this. So, this is a safety risk for both the patients and for us. (FG3 N1)*

The findings further reveal that the Mutawwa (religious men) affected the nurses' ability to provide care. The main issue was that they advised patients to stop taking medication

*I think Muttawa should not be allowed in the hospital, to come and interfere in our care. Sometimes when they come, they educate the patients in their ways and so the patients do not believe on our care and they have more belief in what the Muttawa said to them. I have had personal experience with such patients where, after a Muttawa visit the patients and then leave them, the patients deny our care and say the Muttawa asked us not to do this thing. (FG1 N1)*

#### **4.5.3 Fear of transgression and false accusation**

It was found that a significant part of the nurses' experience was their concern about transgressing cultural barriers and being falsely accused of inappropriate behaviour (particularly in relation to being female and caring for males). This concern was reflected in the fact that the nurses felt that they had to be careful continuously about how they behaved, so that their actions were not misinterpreted. The nurses had to be careful about physical distance and the way they interacted with male patients. One nurse understood what 'professional distance' actually was, but she felt that this distance was much wider in Saudi Arabia and it was more difficult to judge situations. She stated the following:

*Yes, I am a bit more of a relationship maker. But you are always being told to be aware of your relationships, which means when you came to Saudi Arabia you do not want to be accused of doing something inappropriate. So I always keep a professional distance, but it is a wider professional distance than I ever kept with my patients in the West. This is because asking them some things would be considered inappropriate, and you do not actually know which. So when it comes to the distance of a professional barrier, I can easily judge a person in the West, but here I have found this a lot harder to do. And if I make a mistake, I will be out of here. (FG3 N2)*

One of the nurses explained that actions may be misinterpreted, due to culture understanding:

*Yes, sometimes you have to be careful with certain actions, because in this culture something (or some action) is different than in other cultures. The patients can get a wrong impression, or a different feeling from your action. (Nurse 7)*

This idea of being careful is also echoed in the following statement:

*So you should be more conscious in front of male patients of the way you talk, and the way you deal with them. And so you should be very careful. (FG3 N2)*

#### **4.5.4 Language barriers**

The semi-structured interviews conducted with the nurses indicated that over half the participants expressed difficulty in understanding the Arabic language and had communication difficulties with patients. All of these participants specifically referred to this problem as a language barrier. The participants acknowledged the importance of language when they first started dealing directly with patients, and they associated the language barrier with their inability to provide proper care.

One of the participants in the focus groups revealed that:

*We cannot speak to family members, because we cannot speak the same language. They would not take them off to even start some short communication and also it puts up a barrier between you and patient. (FG3 N2)*

Another nurse made a comparison with her own country:

*I think that in my country you and the patients can better understand each other because we have the same language, but here sometimes the language is a barrier. (Nurse 7)*

There was an admission it would make the nurses' work easier if they were able to speak Arabic without assistance. One nurse said:

*Of course, if we do not speak the same language as the patients, then it makes a lot of difference. But we know very little Arabic, so it is hard to explain sometimes to patients without help of an interpreter or translator. (FG1 N3)*

In addition to acknowledging that it was generally an issue, the nurses also felt strongly that the language barrier was an impediment to providing care. They felt that if there was better communication, it would be easier to explain to patients about their care, so that they could act on the advice being offered, and that this would improve the overall care of patients. Moreover, the term ‘barrier’ was frequently used, which implied that the nurses viewed it as a problem. There were a number of different ways in which the language barrier impacted on care, including difficulties communicating with patients and their families, along with a waste of time.

One of the more experienced nurses expressed the ways in which language can affect care:

*In my case, I have only been here for three years. Caring for a Saudi patient is quite a challenge for us, because the first barrier is the language barrier, which I think is the main problem we face taking care of patients here. (FG1 N1)*

The majority of nurses expressed concerns that language has an effect on the ability to provide care. The following are examples of nurses’ concerns:

*I think the most common difficulty here with patients is the communication and language barrier, which we all face. It means we are unable to communicate with patients in their own language and sometimes they are unable to understand what we want them to do. (FG1 N2)*

One of the nurses said that being able to communicate would allow the nurses to explain care regimes to their patients:

*I think that communication is important, and sometimes the patients do not comply with what we advise them to do. They do not follow our instructions, such as walking, and ambulating, and they prefer to sleep and just lie down. So, language is a barrier. I think if I was able to speak Arabic, I could communicate better with patients. (FG1 N1)*

One nurse had to spend additional time discerning her patients’ needs:

*I listen to them carefully. Even I sometimes cannot understand the patients, because their Arabic is different to mine, I will go and ask somebody to explain to me what their needs are, or what they want from me. So they will tell me what the patients or their families want, and in this way I am able to meet the patients’ needs. (Nurse 3)*

It was found that it was the more inexperienced nurses who faced language problems. There was also a sense of expectation among these nurses that English would be spoken in the hospital, and they could use English to communicate with the patients. Their lack of experience, along with problems with language and the expectation that English would be spoken at the hospital, was evidenced by a number of statements.

One of the participants stated that:

*The major issue that I faced when I first started working here was the language barrier. I thought initially that it was an English speaking hospital, but the majority of the patients who come here do not speak English. (Nurse 4)*

Another participant (who was clearly inexperienced in working in Saudi Arabia) supported her colleague's views, since she had also encountered the same problem:

*My first experience was that it is difficult to come here when you cannot speak Arabic, because it is so difficult for the patients when they do not understand you and you do not understand them. So there is a language barrier between you and the patient, which still I think is the most difficult thing here. (Nurse 5)*

The fact that it is the more inexperienced nurses who have difficulties with the language was supported by a nurse who had more experience, and was able to communicate better with patients, albeit with limited Arabic. She said:

*I do not think the language is a barrier, because we have been here for such a long time and we can communicate a little bit in Arabic with the patient. There is also a ward clerk available to interpret what we want to say to the patients. (FG2 N2)*

The nurses also indicated that they had problems communicating with the patients' families. This led to difficulties in explaining care options and procedures and also meant that translators were unavailable to help them. The family unit is very strong in Saudi Arabia, leading to a level of control over patient-care. Thus, if the family do not understand the nurses it can lead them to interfere, as expressed in the following:

*There are sometimes too many problems regarding this, but we are lucky that we have interpreters with us who help us in these situations. As far as the communication with the family is concerned, sometimes we face difficulties regarding the patients' families or sitters interfering with our care. Sometimes they refuse the things we want to do and I think this is*

*due to them not being well explained or interpreted to them, so that what we want to do is not clear. I think communication is really the big problem, but otherwise most of the families I see are really grateful that we are helping the patients. (Nurse 4)*

Evidence from the patients themselves concurred with the evidence from the nurses. The highest level of negative reporting concerning non-Muslim nurses was related to language. Many of the patients expressed their concerns about the language difficulties and this issue was sufficiently significant for the patients to prefer Saudi nurses. In response to a question about why a particular patient preferred a Saudi nurse, the response was as follows:

*Because they understand my speech. (Patient 7)*

Another patient also complained about language:

*Yes, their language may be not understandable. If two of them are speaking I cannot understand what is going on between them. (Patient 1)*

The patient continued to say that she preferred Saudi nurses because she could understand them:

*No one can understand her except somebody who speaks English. The one who is Saudi speaking is understandable. (Patient 1)*

This was also supported in the following statement:

**Researcher:** *why do you prefer a Saudi nurse?*

**The patient:** *I prefer her because of her religion, and also because she understands I and I understand her. (Patient 7)*

#### **4.6 Busy nurses (workload and scheduling)**

There were a number of features in the nurses' experience, relating specifically to the context of caring for Muslim patients in Saudi Arabia, that the nurses felt made their working routine far busier and placed them under additional pressure in terms of their workload and scheduling.

#### 4.6.1 Prayer, fasting and Ramadan

All of the nurses expressed the view that the fact that Muslim patients had to pray five times a day had a significant effect on their working routine and scheduling. More specifically, the nurses had to continuously adjust their working routine to accommodate prayers. This is expressed in the following statements:

*Sometimes there is problem with time management, as sometimes the patients and their families are praying together, and it may take too long and we have to wait until they finish their prayer. (Nurse 4)*

And

*Also, here there is a prayer time and if you want to give some medication or treatment to the patients, or if they have an appointment, they will first ask you to allow them to pray before being prepared to go with you. So, once we have been here for a while with the patients, we become aware that there are specific times when the patients will be praying. We adjust our plans according to their times, so that we do not disturb the patients during prayer times. (Nurse 3)*

Nurses were concerned about important medical procedures being delayed because of prayer. The nurses had no choice but to wait, as illustrated by the following statements:

*For me there is no difficulty if the patient is Muslim or Christian. But when we need to take the patient for a procedure, sometimes they still want to pray and we have to ask the patients to be quick. So these are the times when we have difficulties. (Nurse 8)*

And

*Another thing that I understand and I respect is prayer. You know that you should respect prayer time, but sometimes you get patients who know the fact that there is an urgent procedure or they are waiting, but a lot of them say "I want to pray". Then they will socialise for the whole time, because it is not really a prayer time. They call it prayer time because they want us to allow them some time before going. But once the trolley comes, they start to pray and it is difficult to know what to do. We are being asked why there is delay and all those things. This was my experience, and is really something that took me time to accept and to understand. (FG3 N1)*



And

*Also, the patients pray for 15 minutes or 30 minutes before a procedure, so delaying the procedure. (FG1 N2)*

Nurses also provided a comparison between Muslims and non-Muslims in reference to prayer. This further illustrates that patients' prayer was a significant part of the nurses' experience and it significantly affected the scheduling of their work:

*I think there is big difference between taking care of a Muslim and a non-Muslim patient. For Muslim patients, there are prayer times, and at that time we have to delay any care given to them. For non-Muslims, on the other hand, we can do the care anytime, which I think is a big difference. (FG1 N3)*

Comparison with other religions (in reference to prayer and other Islamic practices) are also made in the following statement:

*With non-Muslim patients, there are no prayer times, no fasting, no covering from head to toe, or wearing dresses. These are the things that make the difference. (Nurse 3)*

The nurses clearly felt that Ramadan had an impact on their working routine. Firstly, during Ramadan patients are awake during the night and asleep during the day, which significantly changed the working routine. Many patients did not want to take their medicine during daylight hours, and the non-Muslim nurses had to cover the Muslim nurses' shifts during this month. Ramadan was particularly significant for the nurses when they first experienced it, and most were surprised by how everything changed in that month.

*I know that in Ramadan things are different, as the patients normally stay awake and meet the visitors during evenings and night-time, and they are sleepy most of the day. But we also change into this new routine and try to not interfere with the patients' religious or other duties. (Nurse 4)*

An important issue that had a direct impact on care was the timing of the administration of medicine. Many of the nurses felt that Ramadan had a serious impact on this, such as the patients who were fasting needing to take their medicine early in the morning or at night. Additionally, during the month of Ramadan patients would tend to sleep throughout the day, because their families would only be visiting them at night-time. One of the nurses commented on this issue:

*During Ramadan, some patients are fasting and it alters the treatment plan, as we have to give morning medications early in the morning and we have to give other medications in the evening, after the patients break their fast. (Nurse 5)*

Another nurse revealed that:

*We learned by ourselves, with the patients, that the medications should be given during night-time and early in the morning and not during the day, as the patients are fasting during daytime. (Nurse 3)*

One of the nurses felt that this disruption to the daily routine would have an impact on patient health:

*During Ramadan, when the patients are fasting, they will be sleeping during the whole day and then they will be awake all night. To be honest with you, this may affect patients' health. (Nurse 5)*

There was clearly an issue about not being prepared for Ramadan in terms of not being informed beforehand by the hospital. One nurse expressed how she had not been informed about Ramadan:

*I came here during Ramadan. I think the world is upside down here in Ramadan, and we were not told anything about what Ramadan is and how things are different in Ramadan. So we were not given any special information. (Nurse 3)*

The perception that the hospital was at fault for failing to inform the nurses about Ramadan is supported by the following statement:

*The hospital has not given us any particular information about Ramadan, they just told us that we can expect the patients to sleep all day and to mostly be awake during night-time. (Nurse 2)*

One of the nurses who participated in the semi-structured interviews said she was shocked by Ramadan, and also commented on the fact that the nurses could not eat publically:

*Usually, when we first come here and it is our first experience of working during Ramadan, then there may be a cultural shock that the things are so different in Ramadan. Even we are not allowed to eat publically in Ramadan. But once we are here for two to three years, we just get used to this. (Nurse 4)*

Other nurses supported this idea:

*In Ramadan, especially when the patients are fasting, we try not to eat and drink in front of patients. (FG2 N4)*

And

*For example, eating in Ramadan publically is prohibited here, whether you are a Muslim or not. These are the kind of things that are stressful. (Nurse 4)*

#### **4.6.2 Gender**

The nurses raised a number of issues related to gender that had a direct impact on their workload and also the scheduling of their shifts. One issue was that some of the male patients did not like to be cared for by female nurses and requested male nurses. This led to nurses having to spend additional time seeking out male nurses. One nurse said:

*I had an old man as my patient who was a religious person, and he said he did not like a female nurse to touch him. So in that case we had to find a male colleague of ours to help us. (FG 2 N1)*

Moreover, one particular nurse felt that having to wait for a male nurse had a direct impact on the patients themselves, because they were not receiving the care that they required on time. She stated the following:

*I find not being able to do all of the care for the male patients quite difficult, because we have very few male staff. So in order to get certain things done for male patients, you have to wait and wait and wait, because nobody is there to do it. I find that a little bit odd, but it is a religious thing and you just have to accept it. It does not really impact on my life a great deal, but it does impact on a patient's life, because they have to wait to get the care that is required, because there is not a male nurse to do it, or a male doctor. So that means I cannot really do much for that particular patient. (Nurse 2)*

While nurses understood why they frequently needed to wait for male colleagues to nurse certain male patients, they also felt that the male nurses had a lighter workload, because they only cared for male patients, in contrast to the female nurses, who cared for both. This feeling

of inequality was compounded by the fact that female nurses had to waste time waiting for male nurses. The following statements demonstrate how one nurse felt about this issue:

*Nursing is certainly very different here. As a female nurse there is limited nursing you can do for male patients. I found that somewhat odd, because the male nurses tend to get a very light load, so that seems unusual for me. (Nurse 2)*

And

*Likewise, you know we have male nurses on their wards working with very light patient loads. Sometimes, because all of the patients are female, so there will be three male nurses on board, and they will have one or two patients each. Female nurses have 4 or 5, because the male nurses cannot work with the female patients, and you cannot always predict that you are going to have a certain ratio of male or female patients to nurses. (Nurse 2)*

Moreover, the workload of the female nurses was further compounded by the fact that the male nurses in this study required the assistance of a female nurse when dealing with female patients. Therefore, as well as having to wait for male nurses to assist them, female nurses had the additional burden of helping their male colleagues who were unwilling to care for female patients alone. One of the male nurses stated the following:

*Regarding the female patients, there is sometimes a difficulty in that I am always hesitant to enter a female patient's room, because it is against the culture here. So I am not free when taking care of female patients and I am somewhat restricted. (FG1 N1)*

However, the issue was not only male patients requesting male nurses. Female patients also made it necessary for the female nurses to dedicate more of their time to them, because female patients often requested the presence of a female nurse in the room during doctor's visits, as illustrated by the following:

*Also, if there is a female patient inside a room, we as female nurses need to accompany the doctor all the time he stays inside room. I think this is also a different practice than in other religions. (FG1 N3)*

Moreover, there was also the issue that male medical staff had to wait for female patients to cover themselves. The following statement demonstrates how the need to cover could actually interfere with the care and affect the schedule:

*Sometimes the doctors are in hurry, but we have to wait to see the patient until she covers herself and she allows us to come in. (FC3 N3)*

#### **4.6.3 Lack of translation services**

Many of the nurses expressed their frustration at having to wait for the interpreters providing a translation service between the nurses and the patients, leading to their conclusion that there were not enough interpreters. The problem of wasting time in seeking help was compounded by the fact that hospital translators were not always available, and therefore nurses had to spend time looking for them:

*I do not know why the translator is not available. Maybe there is a lack of staff. So, due to this, I sometimes find someone there who can speak Arabic and explain to the patient. At times, if there is no one around, I have to wait for somebody to come and explain to the patient. (Nurse 7)*

Moreover, because interpreters were not available, the nurses had to spend additional time looking for other people who work in the hospital to help them understand what their patients actually wanted. As one nurse said:

*I heard 'Bismillah' and sometimes I heard patients say 'Akul, Akul'. I did not know what Akul meant, and so I asked one of the ward clerks. They explained that he is hungry and he wants food. So he taught me that word and now I know it in English and Arabic. So, you just kept asking around, asking about what a word means. (Nurse 2)*

#### **4.7 Not respected**

It was very clear from the results that all of the nurses expressed a sense of not being respected. They attributed this to the religion and the culture, as their concerns included that this lack of respect came from the fact that they were female, and also were not Saudi or Muslim. Moreover, the nurses felt that the institutional culture itself created an atmosphere of a lack of respect for the nurses, and was particularly biased towards the patients.

#### **4.7.1 I am a female, expatriate non-Muslim nurse**

Whilst there was a high degree of respect for the Islamic faith, some of the nurses felt that the respect was not entirely reciprocated. There were a number of complaints that the nurses were sometimes under pressure to convert to Islam, or were questioned why they were not Muslim. The following statement by one of the nurses is an example of such an experience:

*Generally, the patient feels very happy with us. But some patients ask us questions, such as if we are Muslim. They say “you should be a Muslim”. Sometimes the patients give us booklets to read about Islam, meaning that we have to make them understand that we cannot be a Muslim because our families belong to different religions. So it is a big issue. (FG2 N1)*

The following statements support the idea that nurses felt that their own beliefs were not respected:

*I want to add something about the fact that the patients here are very curious about our religion. Every time we go to a patient, he will ask us if we are Muslims and they say that we should be Muslims. (FG3 N5)*

And

*Sometimes the patients just keeping asking us if we are Muslims, and why we are not Muslims, and other such questions. Then we have to keep quiet, because we respect the patients and do not want to argue with them. (FG2 N4)*

The following statement demonstrates that one of the nurses felt strongly about this issue and considered it a personal invasion:

*I have been here since 2008. When it comes to religion, many times when we go inside the patients’ rooms they will ask if I am a Muslim. If I say I am not, they ask why I am not a Muslim, which I think is a personal matter and the patients should not ask us about our religion. (FG1 N3)*

Moreover, some of the nurses felt that they were under pressure to conform to Islamic religious requirements themselves, which they felt was disrespectful to their culture or beliefs. There were cases where both patients and the Mutawwa (religious police) would require them to wear a hijab. The nurses said they felt that this was irritating, as illustrated in the following statement:

*Also, when I go into the rooms of female patients they ask me to cover my hair, and ask why I am like this or like that, etc. Once, a Muttawa came inside the hospital and he was asking all the female nurses to cover their heads. He said he is a policeman of the country and we should respect him. I was in clinic taking care of a patient and he started shouting at me to cover my hair, so I called Patient Relations and my Head Nurse to talk to him. (FG2 N4)*

The nurses also perceived that the lack of respect towards them was because they were female in a male dominated society. The issue of male dominance was raised by the nurses as presenting itself in a number of different ways. The nurses noted that Saudi Arabia was very much male dominated and that they were sometimes at the receiving end of male dominance in their work, which presented itself as rudeness towards them and a lack of trust. Moreover, this was true of all males the nurses had encountered, including doctors and patients' families. This is clearly illustrated in the following statement:

*For example, the men here, they feel they are more powerful and sometimes they are rude. They look at us in a bad way and they do not understand that we are taking care of their relative like a family would, but they will just say "I want to see the patient now". When we tell them that they cannot see the patient immediately, because we are cleaning them, they go and talk to a male in the locality because they do not trust us. They do not wish to respect to us, especially the men. But the women are good, and we do not have problems with the patients. (Nurse 6).*

When the nurses spoke with male doctors in the course of their work, the doctors also did not respect their professional opinions and they felt that this was clearly related to the culture. The following nurse felt strongly about this subject:

*Here, I've also noticed that the doctors sometimes do not listen to us and our suggestions have no value to them. I think this is due to male dominance. There is a perception in The West that Muslim males always try to be dominant over females and they do not care about them. So as women here, we do not have as much respect as we have in our culture. This is the perception here. (Nurse 1).*

There was evidence that such male dominance was not just a perception of the nurses in relation to a lack of respect, there was one example where the nurses noted that male dominance officially affected patient care:

*Also, there is another issue about signing the consent forms, because it is the men who signs the consent and women have no right to say any word about it. Because a woman cannot give any consent for any procedure, they have to wait for a man to sign it. This is because they think a man has more responsibility and women are not responsible enough. (Nurse 6)*

There was a strong feeling among the nurses that they were not respected because they were expatriate; more specifically, because they were not Saudi. They felt that patients did not respect them, and that they were often treated as servants or slaves. There was a general, consensus amongst the nurses about this issue. One of the participants stated that:

*Some patients think that we are just here to serve them, like their personal servants. They throw things around the room and want us to do this, do that, and clean that. Sometimes we feel as if we are servants. (FG3 N3)*

One of the nurses indicated that their professionalism was not recognised, and thus they were reduced to being servants:

*Regarding the culture here, I think most of the patients consider us as servants. They do not consider us as nurses or professionals, but just their servants. (FG2 N2)*

Another nurse in the same focus group said that she had experienced a lack of respect because she was not Saudi:

*I have worked in around 20 places all over the world, but I think nursing is not as hard anywhere as in Saudi Arabia. Here, we face a lack of respect for us as foreigners; the people here say they are always right. Even if there is some problem with the patients and we complain, they always take the side of patients. (FG3 N2)*

There was a support for the idea that Saudi citizens were preferred over the expatriate nurses, as the following statements illustrate:

*One thing I also noticed here was the lack of mutual respect. I think patients and healthcare providers are both respectful, but here I noticed that the patients are given more respect and the care providers are just ignored. (FC3 N4)*

And



*I think the Patient Relations department takes the side of the patients, because the patients tell them lies about us and they believe them. Patient Relations have more trust in Saudi patients than us, because we are not Saudis. (FG2 N3)*

This feeling of not being respected was also found in the relationship between the nurses and the doctors. There was a feeling that the doctors did not respect nurses as professionals in their own right. This was illustrated by comparative examples with other countries. The following statements clearly demonstrate the feeling of a lack of respect for their professional opinions and an overall feeling of denigration:

*One thing I would like to add again is that we as nurses are not listened to here, especially by doctors. We are taking care of patients and we spend more time with the patients. Sometimes we have suggestions about the patients' care, but the doctors do not listen to us. I know that we should not take the place of a doctor, but sometimes we feel that this kind of care would be better for the patient, as we have spent a long time with the patient and know their response to certain treatments. For example, I work in neonatal wards and I have a baby who is not doing well on the formula he is being given, and I think it should be changed. I told the doctor this, but he would not listen to me. I have had experience of doctors not listening when we suggest they take a certain action, but later, maybe after 3-4 days, they will do exactly what we told them to do. If you have an issue like this in the US, we feel free to talk to doctors and they pay attention to what we say. This sometimes frustrates me here. (Nurse 1).*

The same nurse continued to state the following about doctors in the United States:

*Although there are also some doctors (in the US) like the ones here, most will listen to us and pay attention to our suggestions. For example, if I suggested there that the baby's formula should be changed, they would listen and change the formula. In this way, we feel that we are a part of the patient's care. But here the things are not like that. Most of the doctors here in King Faisal Hospital do not listen to the nurses. (Nurse 1)*

However, there was some indication that attitudes among Saudi patients had changed for the better in relation to treating nurses as servants. In the semi-structured interviews one nurse noted:

*I think the patients in the past were more respectful and humble, but at that time when I was impatient, when the patients they saw that I am Filipino they just asked me many questions and would treat me like if I am a servant here. But now, after some time, the patients are*

*more educated and now they know that there is a difference between a nurse and a servant or maid and they treat us accordingly. (FG2 N1)*

Overall, the nurses felt that they did not hold the same status as Saudis. There was also evidence from the interviews with the patients that, in addition to cultural and religious reasons, there was a sense of compatriotism when they expressed a preference for Saudi nurses. Some patients suggested that, although Saudi nurses may not have the required knowledge or experience, they should be given a chance.

Moreover, it has already been demonstrated that patients believe that non-Muslim nurses are more professional, and that this is an overriding factor when formulating opinions. However, some patients stated (without citing religious reasons) that if the Saudi nurses had the same level of experience they would prefer them, due to the issue of compatriotism. The following extract from an interview that supports this viewpoint:

**Patient:** *if the Saudi is experienced, then I would choose him.*

**Researcher:** *even if his qualification is low?*

**Patient:** *yes even if his qualification is low.*

**Researcher:** *why?*

**Patient:** *so as to help him to develop himself.*

**Researcher:** *as if you have patriotism?*

**Patient:** *surely, of course if we are always choosing foreigners the Saudis will not develop.*  
*(Patient 2)*

This patient continued expressing the importance of compatriotism:

**Researcher:** *do you think that we still require foreign nurses, or not?*

**Patient:** *if there is a chance to use Saudi employees, surely it would be better.*

**Researcher:** *should they be as qualified as foreign nurses?*

**Patient:** *yes surely. I mean, no one has been born with knowledge, thus they will be developed, Inshaallah. (Patient 2)*

The following statement clearly shows that nationality is important:

*A foreigner cannot give us the same care as a Saudi, because the patient himself is a Saudi (Patient 1)*

#### **4.7.2 The institution**

Throughout the study, many of the nurses expressed that they felt degraded, due to the fact that they were not afforded the respect that they felt they deserved by the hospital itself. Some of the nurses blamed this on the culture of the hospital, rather than on individuals. Part of this culture was that (as mentioned previously) Saudis (and particularly patients) were always preferred over the nurses. One of the nurses reported that she felt that the patients were considered to be more important, and as a consequence she felt debased. She stated that:

*In the UK, if we have a problem with some of the patients Security will be called and they will understand the situation. Here, I think the patients are listened to more and what I have a general impression here is that I am being treated as a slave. (FG3 N2)*

#### **4.8 Inadequately trained**

Cultural orientation is very important in helping individuals to understand and deal with people from other cultures. It is important that through their training the nurses gain an understanding of cultural factors that have a potential impact on their provision of care. This study found that there was insufficient training in this area.

##### **4.8.1 Training and orientation**

The semi-structured interviews and focus group discussions conducted with the nurses revealed that there was a general agreement that training and orientation was, at worst, non-existent and, at best, insufficient. Orientation took place either prior to arriving in Saudi Arabia, or upon arrival before they commenced their duties, or both. There were a large number of cases where the nurses said there was no orientation at all, and that this had an impact on their experience. One nurse said in reference to other nurses:

*So, the persons who come in this way without any orientation about the culture here, they just have a culture shock, and they have difficulty to adjust and stay long here. (Nurse 3)*

The nurses who were given a degree of orientation felt that it was very limited in terms of culture and religion, and that it focussed purely on the Arabic language. Moreover, orientation included other areas, such as hospital procedures. Evidence that culture and religion are not included in the orientation can be found in the following statements:

*We do not have any special training per se. When we first came to Saudi Arabia to work, we have to think of this aspect. There is generally an orientation at this hospital and that is basically touch base, fairly broadly and we know a lot of things, the cultures, the religion, the hospital itself, the cause, and the procedures. (Nurse 2)*

And

*For us, there was a subject covering multiculturalism, but it was not specific to Muslims. We are living in a highly multicultural society and in general we have been taught about the different cultures of different people. (FG1 N1)*

And

*No, I was not given any orientation regarding the culture. I was given Arabic classes, but I only learned how to read, write and speak Arabic. (Nurse 3)*

A participant who arrived in Saudi Arabia approximately ten years ago, discussed her learning about the culture prior to arriving in the country, revealing that:

*I had some kind of pre-departure training, where they told us some basic things about Muslim culture. There was also some general information about Saudi Arabia, including about the laws here, and that you cannot drive and cannot go outside without wearing an abaya. (FC1 N3)*

When religion and culture were included in the orientation, it was often provided by the recruitment agencies and not the hospital. When the hospital did provide orientation, they touched on culture and religion, but again this was found to be limited. In reference to orientation from the recruitment agency, one nurse stated the following:

*I was not given any training here, but I was given an orientation from the recruiting agency that brought me here. They gave me some basic information about culture and religious matters. (FG3 N2)*

Moreover, it was acknowledged by the majority of the nurses that culture, in particular, was an important part of their experience in Saudi Arabia, and that it was not properly addressed in training. The following statement illustrates this:

*It (training about the culture) would be very beneficial for those who are hired in Saudi Arabia. Here, I believe you need more orientation than other countries, and if you have this, you will be able to better understand the culture here, because the culture is the thing that matters most. (Nurse 6)*

The nurses were provided with basic information about prayers and the required etiquette during the month of fasting. The following nurse felt that this was insufficient, and that she learnt more through her own experience:

*When we arrived, we were given an orientation here in the hospital. We were told some basic things about Muslim patients, such as we should respect prayer times and when the patients are praying we should wait to give them any treatment until they finish their prayers. Also that we should not eat in front of patients during Ramadan, and things like that. I think the orientation was insufficient, and we learnt a lot more from our experience when we stayed here and did our caring work, and this has taught us more than any orientation (FG3 N4)*

The following statements support this idea. However, here the nurse makes reference to the fact that they were not given sufficient information to understand Islam and how to engage with Muslim patients:

*During our general orientation, all we were told about patients here is that they pray five times a day, and that we need to wear an abaya when going outside, and some other simple things. However, they did not instruct us on how people think and how to deal with them. (FG1 N2)*

And

*Our orientation was more about culture, and we were told very little about the religion here. I think we should have been more educated concerning the religion and Muslims, so that we would have been better able to understand the patients and their needs. (FG2 N3)*

Although here the nurses felt that there was more emphasis on language rather than religion, there was also evidence that even the Arabic classes were extremely limited, as suggested in the following statement:

*I had an orientation here, which I think only slightly helped me, because I was just told about some common things and it was also for a very short period. There was only a two-hour course in the Arabic language, when they just gave us some words and their English translation, which I think is not enough. (Nurse 4)*

The nurses acknowledged that they had received some Arabic classes from the hospital. The overall impression was that these provided very minimal language skills, or they taught reading and writing skills deemed useless when caring for patients. Moreover, these classes were overbooked, or were not well promoted by the hospital. The following statements from one participant clearly showed the desire to learn language skills that are suitable for their work:

*I want to have an Arabic class, but I think it would be good to have just a conversational Arabic class. The class at the moment is much geared toward learning aspects of a language like writing and reading, etc. That seems to me a very long way round to getting know some of the words. I would like more conversational classes and ones on medical language, so that I can walk into the room, say hello and tell them I am their nurse, and then ask them about themselves and be able to ask them about simple nursing things. (Nurse 2)*

And

*I just want to be able to speak to them and get answers for my questions. But they give us pages which are, for the most part, general and have nothing to do with nursing. All words directly related with medical issues would be good. (Nurse 2)*

The nurses who participated in both the semi-structured interviews and focus groups expressed a willingness to learn Arabic. However, there was a clear indication that the level of Arabic was very basic. The following statements support this:

*Yes, I attended a class and I learned some Arabic words for basic things. (Nurse 1)*

Another participant said that:

*I did a number of courses in Arabic, through which I learnt words used in a patient's daily life. (Nurse 6)*

Much like the willingness to understand religious and cultural sensitivities (revealed later in the study), nurses had also attended Arabic classes prior to arriving in Saudi Arabia:

*I attended a course in Arabic before I came to Saudi Arabia, which gave me an idea about the language, such as using 'Marhaba', 'Salam Alikom', etc. (Nurse 7)*

#### **4.8.2 Dependence on self-learning, working experience and colleagues**

There was recognition by the nurses that there was a need to understand the patients' religion in order to provide the appropriate care, as illustrated by the following statement:

*Yes, because we have to understand the culture here and the policies being followed. It is also good to have Arabic classes to learn the Arabic language. We also need to learn more about the religion of Islam, because we are from different religions. This means we are not sure which aspects are different in Islam, and how we should take care of the religion of the patients while providing them with care. (Nurse 8)*

However, there is a considerable amount of evidence to suggest that nurses felt that, due to their inadequate training, they were forced to depend on their own efforts and experience (as well as that of their colleagues) to gain an understanding of Muslim patients in Saudi Arabia and therefore be able to provide effective care. Moreover, the majority had made an effort to learn the culture and language before they arrived. The following two extracts are from the semi-structured interviews and clearly highlight the above issues of insufficient orientation and training and dependency on self-learning and colleagues:

**Researcher:** *have you taken any course or some sort of orientation when you first join the hospital?*

**Participant:** *yes I had a little training in form of General Nursing Orientation, where a nurse told us about the culture here. It was helpful.*

**Researcher:** *how did find the orientation?*

**Participant:** *I think when I first came here, there was not very much orientation and training. It should be more extensive.*

**Researcher:** *how did you cope with difficult situations?*

**Participant:** *to be honest with you, my colleagues who had been in Saudi Arabia for some time helped me and explained about Saudi culture. However, it takes a long time to understand the Islamic religion and Arabic culture. (Nurse 5)*

The following conversation also reveals the need for better training and orientation alongside this dependency on others:

**Researcher:** *how did you learn about Saudi culture?*

**Participant:** *I taught myself, and also gained some help from my colleagues from Jordan (in Egypt) and some Saudis.*

**Researcher:** *was the orientation sufficient to understand the Saudi culture?*

**Participant:** *I believe you need more orientation here than in other countries. If you are given this, you will be able to better understand the culture here, because the culture is the thing that matters most. I learned a lot about the culture here from my patients, my friends and my experience here in the unit where I am working.*

**Researcher:** *what do you recommend should be done to improve this?*

**Participant:** *it would be very beneficial for those who are hired to work in Saudi Arabia to be given long-term training related to understanding the religion and culture. Short courses are not sufficient to grasp everything in a few hours or days. (Nurse 6)*

Some nurses attempted to learn about Saudi culture, and local values and attitudes, either before, or during, their time in Saudi Arabia. More specifically, there was evidence of a conscious effort to learn about the culture in some way before arriving in the country:

*I learned by myself, and gained my own experience. I read books and if I do not understand anything, I ask my colleagues, and even patients. In this way, I have learned a lot about the culture and other traditions here. (FG N1)*

The study found that the majority of the nurses used their own initiative to learn about the religion, culture and language. In addition, the nurses also reported that they learned from, and depended on, their colleagues for support. One of the participants revealed that:

*We learn a lot from our colleagues here. If I am unable to understand something in Arabic I will ask a ward clerk or another nurse who understands Arabic. (FG1 N2)*



In addition to self-learning, the nurses also reported that they learned from their own experience, particularly when it came to caring for Muslim patients. Moreover, learning from experience was, at times, associated with a lack of training, as stated by one of the nurses:

*Yes, I think we need a lot of training about Muslim patients, and an overview about caring for Muslim patients. Since I have not received enough training, I started teaching myself with my day-by-day experience here, taking care of patients and learning from my experience with patients, their families, and my colleagues. (FG1 N1)*

Another nurse also supported the idea that a lack of training made them depend on their experience:

*I think orientation is not enough, and we learn a lot from our experience when we stay here and do the caring. That teaches us more than any orientation. (FG3 N4)*

This dependence on learning from experience rather than from formal training is clearly illustrated in the following statement from the same nurse:

*In Saudi Arabia, we feel that the patients are our teachers, and we have a lot to learn from them. (FG3 N4)*

Another nurse also supported the idea of learning from experience in relation to learning the Arabic language:

*Yes, I attended classes in Arabic, and I learned some Arabic words for basic things from my friends in the hospital. You know, it is now 20 years since I learnt how to talk to my patients. (FG1 N1)*

This positive attitude by the nurses to learning about Saudi culture from their experience was also reflected in the focus groups. One of the participants stated that:

*I learned about Saudi culture from those who have been working in Saudi hospitals for long time, and I have accumulated a good deal of knowledge about the culture. (Nurse 3)*

The need for the nurses to teach themselves, or to learn from their own experiences or from colleagues, is also reflected in the fact that they felt that limited opportunities were offered to learn about Saudi and Muslim culture before their arrival. Many nurses recommended that there should be courses in Arabic culture and Saudi customs and traditions before their arrival in the country, as stated by one of the participants:

*I recommend that a course should be available in our home countries, one that we need to complete before starting work here. I think the recruitment agencies in our home countries should have such a course for those who are coming to Saudi Arabia, so that we can learn some basic things before we come here. (Nurse 3)*

This statement is supported by another participant who reported that:

*Yes, I think we need a lot of training about Muslim patients, and also an overview about caring for Muslim patients. Since I did not receive enough training, I started teaching myself from my day-by-day experience here, taking care of patients and learning from my experience with patients, their families, and my colleagues. (FG1 N1)*

#### **4.9 Conclusion**

This chapter has presented the findings of the study, organised according to the themes that have emerged. The chapter provides an insight into the experiences of non-Muslim nurses caring for Muslim patients in Saudi Arabia and demonstrates the ways in which religion and culture are significant factors in these experiences. The nurses discussed the meaning of religion for them during their experience of caring, frequently discounting it as a factor affecting their ability to provide care. However, the findings reveal that, in reality, religious and cultural factors had an impact on their ability to provide care and on their working experience in general. Overall, there tended to be a few positive perceptions of religion and culture as a feature of their experience.

Chapter Five will discuss the findings of this study in relation to the current literature concerning transcultural nursing, and in particular the experience of caring for Muslim patients. This will place the Saudi context into the perspective of the work of other researchers. The chapter will also discuss the implications of the findings on nursing practice in Saudi Arabia.

## **CHAPTER FIVE: DISCUSSION OF THE MAIN FINDINGS**

### **5.1 Introduction**

The purpose of this study has been to explore the experiences of non-Muslim nurses caring for Muslim patients in Saudi Arabia. The study has explored these experiences in order to reveal the meaning that nurses have given to the experience of working in a Saudi hospital. In exploring the views of the nurses, issues contributing to the existing body of literature regarding transcultural nursing have been revealed, focussing in particular on the issue of religion in Saudi Arabia. The research question posed by the study is: What does it mean to be a non-Muslim nurse caring for Muslim patients in Saudi Arabia? The study has adopted a Heideggerian hermeneutic phenomenological approach in order to establish the answers to this question.

Religious factors were shown to have a significant impact on non-Muslim nurses' experience of care in KFSH & RC in Saudi Arabia. This study has demonstrated that the overall impact is negative, with nurses feeling that this issue has affected them both personally and professionally. The study also revealed that the relationship nurses have with their patients not only reflects their experience when religious and cultural factors play a role, but also in light of the organisational culture of the hospital, including the cultural attitudes of other staff and the patients' families themselves. All of these display the classic cultural characteristics observed in Saudi Arabia and all have had an effect on nurses' experiences when caring for Muslim patients.

The problems expressed by the nurses have been both extensive and complex. It is important to note that, although the study primarily focuses on the issue of religion, factors related to culture and language also form part of the overall experience. Although they were highly respectful of religion and others cultures, the nurses held both the religion and culture of Saudi Arabia responsible for the difficulties they experienced. They also felt it necessary to defend their professionalism, stating that, despite the difficulties arising from religious and cultural factors, they would not allow, or admit to the fact, that such factors had in any way affected their professional ability. An apparent contradiction was raised in that the nurses cited many examples where religion and culture impeded on their ability to provide care. This defence of professionalism was found to be a major theme throughout the study.

The nurses also referred to issues related to Saudi culture and language. However, it was established that the nurses frequently confused religion and culture, which was understandable given the close link between the two. A number of themes emerged during the course of this study related to religion, culture and language. Overall, it was found that religion and culture dominated the experience of nurses, and were negative aspects of their experience of caring. These were followed by issues of language, which were also viewed as being a barrier to communication, and therefore an impediment in the provision of quality care.

These findings are supported by a number of previous studies with similar outcomes, particularly in relation the following: (1) the practical implications of caring for Muslim patients; cultural issues (such as the role of the patient's family and the issue of covering); (2) respect for nurses and their beliefs; (3) and also issues relating to language (Halligan, 2006; van Rooyen et al., 2010; al-Shahri, 2002; Luna, 1998). The current study also reveals that the nurses believe that they are acting professionally, which is reflected in the fact that they work to accommodate religious practical needs. They further saw themselves as being pragmatic in their approach to the difficulties they face. However, they demonstrate less concern for the spiritual needs of patients. The study identified that a lack of training specific to the Saudi context was a contributing factor to the experience, and if this was addressed appropriately it would help the nurses to cope with working in Saudi hospitals and to provide improved levels of care that are also more culturally congruent.

This chapter consists of the introduction followed by eight subsequent sections. The theme of the second section is the nurses' understanding of religion and spirituality, and the difference between the two. The third section focuses on Islamic religious practices (including prayers and fasting in Ramadan) and the difference between culture and religion. The fourth section addresses the issue of cultural competence and its impact on the provision of services to Muslim patients, including: training and orientation; cultural awareness; knowledge and sensitivity. The fifth section discusses professionalism and the impact of the training and orientation given to nurses working in the Saudi local culture and language. The sixth section discusses language as a barrier to providing a high quality of health care services. The seventh section discusses the social aspects that affect the provision of care (including family interference in decision-making when it comes to patients' care; decisions related to patients; respect and the role of nurses in the hospital; emotional aspects of nurses and patients; and

gender issues). The eighth section discusses workload, stress and safety of patients. The final section summarises the main points of the chapter.

## **5.2 Understanding Religion**

This section discusses the results of the interviews and focus groups conducted with both nurses and patients. There will be a particular focus on nurses' understanding of religion and spirituality, as well as the effect of religious issues on the quality of services provided to patients. This section will specifically cover the understanding of Islamic spirituality and religious congruency.

Non-Muslim nurses who took part in this study were questioned about their understanding of Islamic religion and spirituality in relation to Muslim patients' faith in their recovery and medication. Religion and spirituality were regarded as the main themes addressed in the research questions and frequently emerged in the interviews conducted with both nurses and patients.

The study results indicated that, to some extent, non-Muslim nurses understood the different aspects and practices of the Islamic religion (e.g. praying, fasting and spirituality). However, they did not understand the importance of religion and spirituality to Muslims in general, and to patients in particular. Nurses believed that religion was simply a set of certain practices. They did not realise that the Muslim religion consists of faith and spiritual beliefs that assist patients in their reliance on Allah (God) to help them recover from illness. Religion and spirituality are important, not only for Muslims, but for other religions and faiths as well. For example, a range of studies have established a positive correlation between religiosity or spirituality and indicators of health. In their study of African American female patients, Ball et al. (2003) demonstrate that the patients' involvement in religious activities decreased both morbidity and mortality. These findings are in line with the results of the study conducted by Oxman et al. (1995), which established that religiousness correlated with improved outcomes after major illnesses and medical procedures. These results also concur with Pressman (1990), who showed that lower levels of depressive symptoms and better ambulation status were associated with greater levels of religious beliefs. Van Ness et al. (2003) also looked at whether religious faith improved the survival of patients with different illnesses. The authors found that African American women with breast cancer believed that their survival rate was improved as a result of their faith.

Puchalski (2013) demonstrated that patients wished for their spirituality to be addressed in their medical care. Aspects of belief (such as family, naturalism and humanism) are all factors able to influence the ways in which both patients and healthcare professionals (i.e. nurses) perceive health and illness, as well as their interactions with one another. It could be said that spirituality is an integral part of the lives of all Muslim patients and their families. For example, Mebrouk (2008), in her study on perceptions of nursing care and the views of Saudi female nurses, indicated that the values of nursing and perceptions of care were closely related to Islamic values. The study found that the most challenging aspect was the negative public perception of nursing as a profession for Saudi women.

Although a number of studies emphasise the positive correlation between religion and health, others indicate that religion has negative impacts on the provision of healthcare. Donahue (1985) indicates that a reliance on spirituality and religion, linked with non-compliance with regular medications, negatively affects patients' health status. Mitchell et al. (2002) studied 682 women in North Carolina, establishing that their belief in religious interventions had delayed the African American women from seeing their physician for breast lumps. Moreover, Lichtenstein (2003) indicates that religion could stigmatise those with certain diseases to the point where they would not seek appropriate medical care.

It should be stressed that spirituality in the Islamic religion has two dimensions: vertical and horizontal. The former focuses on the individual's relationship with the transcendent, while the latter centres on the relationship with the self, human beings and nature. Accordingly, religion provides the spiritual path for salvation and a way of life (Karmollahi et al., 2007). It could be understood from their spirituality that non-Muslim nurses may not understand, or even imagine, the way in which spirituality is embedded in Muslims. Additionally, it could be said that non-Muslim nurses are required to significantly understand the impact of religion on Muslim patients' daily life, particularly when in hospital. Building a trusting relationship with the nurses is important in order for their religious practices to be supported. A study conducted by Shroeder (2010) on Amish beliefs argues that although 'Amish' is not a religion, its followers believe that God is the ultimate healer of patients. Although many studies have addressed the relationship between spirituality, religion and healthcare, this relationship is still not fully understood and continues to be controversial. In their study on attributes of spiritual care in nursing practices, Sawatzkey and Pesult (2005) suggest that spiritual nursing care is an intuitive, interpersonal, altruistic and integrative expression, contingent upon the nurses' awareness of the transcendent dimensions of life, but also reflects

the patient's reality. The results of the current study also established that there was a significant relationship between spirituality (i.e. the Islamic faith) and the provision of health care, i.e. nurses believed that religious and spiritual practices had an effect on care. According to Jennifer (2006), spirituality was integral to early nursing practices, and religious orders prepared nurses to care for all patients, regardless of their religion, ethnicity, colour or nationality. Furthermore, nursing has been developed into a more scientific discipline, focussing on education and research (Jennifer, 2006). It could be said, therefore, that spirituality is not only important when providing healthcare, but also at the level of nursing education and research.

### **5.3 Religious Practices**

#### **5.3.1 Prayer**

One of the five pillars of faith in Islam is prayer, where Muslims have to pray five times a day. The results of the interviews and focus groups conducted with the nurses indicate that the prayers practiced by Muslim patients had significant effects on the provision of healthcare. The interviews revealed various ways in which prayers affected this provision by non-Muslim nurses, including the following: the timing and administration of medications; delays in procedures; and changes in routine work of nurses. Therefore, nurses needed to schedule medication in accordance with prayer times. The findings of this study are in line with the results obtained from South African nurses working in hospitals in Saudi Arabia (Borrick, 2011), where the author found that patients' prayers disrupted the timing of medication, since there were specific times for taking medication (Borrick, 2011).

Atarodi, et al. (2013) state that prayer is considered as a form of medication, through which patients were able to pray for their recovery. The nurses emphasised that a patients' prayer was a significant part of their own experience, as prayer affected their work schedule and added to their workload. They reported that they had to wait for patients to finish their prayers, as well as accommodating their schedule according to the timing of prayers. In the context of Islam, there is no spirituality without religious thoughts and practices. Prayer is one of these practices (Karmollahi et al., 2007). A study conducted by Bohmig (2010), found that nurses supported patients and prayed in front of, and with, patients. The study also stressed the importance of nurses' encouragement in patients' prayers. Patients were grateful for the encouragement and the nurses' promises to pray with them. It would be difficult for

non-Muslim nurses to pray with their Muslim patients, but they could play the role of supporter, appreciating the patients' illnesses and assisting them to be psychologically at ease.

Although Muslim patients have certain concessions not to pray and/or fast, Muslims in general (and patients in particular) believe that their prayers strengthen their relationship with Allah (God), to the point where this relationship may not be regarded as perfect without performing prayers (Atarodi, et al., 2013). From the religious and congruent point of view, healthcare providers (including nurses) are required to be aware of Muslim patients, since religion affects daily life. Performing prayer also requires ritual cleaning. The functional role of the nursing team is aimed at facilitating the resolving of issues negatively impacting the quality of life of patients (Atarodi, et al. (2013).

### **5.3.2 Fasting in Ramadan**

The study results indicate that fasting in the month of Ramadan has an impact on the provision of healthcare, since patients slept all day and were awake all night. According to the results of the interviews and focus groups conducted with the nurses, fasting essentially changed their routine and the timings and administering of medication. Many patients refused to take any medication during the day, due to the fact that they were fasting, and hence it was necessary for nurses to work in shifts during Ramadan. The results also revealed that newly appointed nurses were more likely to face problems during Ramadan and were surprised by the events during that month. A study conducted by Mubeen et al. (2012) on Pakistani female patients and the services provided by nurses, found that physicians and nurses faced the difficult task of advising women about the safety of fasting during pregnancy. The authors also found that women were not able to understand the beliefs and practices of fasting during pregnancy in order to take appropriate measures according to the health of an individual. Although patients are allowed a temporary concession from fasting, some preferred to fast. However, this depended upon the advice of the physicians (Al Mutairi & McCarthy, 2012).

Patients frequently perceived illness as a trial sent from Allah (God). Muslims also believe that there is a cure for every illness, although it may not yet be known. It was clear from the findings, that the patients in this study did not understand that complications might result from not taking their medication at specific times. Leiper (2003) argues that it is difficult for patients to follow a regular schedule, particularly when taking medicine on an empty



stomach. This aspect has also been addressed by Perk et al. (2001), who argues that patients' misuse of drugs during Ramadan increases the risk of therapeutic failure. In general, the majority of patients in Muslim countries change their dosing schedule during Ramadan. The nurses also demonstrated their shock of at what was occurring during Ramadan, because they were not allowed to eat during the day in public places, along with the fact that patients and visitors despised nurses when they saw them eat. In a study on South African nurses working in Saudi Arabia, Van Rooyen (2010) found that, although the nurses were allowed to eat during Ramadan because they were non-Muslims, they experienced discrimination, unfairness and dehydration.

A further issue reported by nurses was that family members and friends came only at night during Ramadan because patients slept during the day. From the semi-structured interviews and focus group discussions, it was clear that the nurses had not been fully made aware of the importance of fasting during Ramadan for Muslims and Muslim patients. According to Islamic teachings, patients are permitted to refrain from fasting during Ramadan if they are not feeling well and are given concession by their doctors. Although nurses were affected by the fasting in Ramadan, it was clear from the results they were not completely aware of the importance of fasting for Muslims, and particularly patients. It is important to note that the importance of fasting stems from the fact that Ramadan comes only once per year, and if Muslims miss that time, they need to wait for another year, even though those who are sick, pregnant women and those travelling for long distances are also given permission to drink and eat during Ramadan.

### **5.3.3 Religion and Culture**

One of the sub-themes that emerged from the data was the confusion made by the nurses between culture and religion. The study results demonstrate that nurses understood, these differences. There was a clear indication in the findings that the nurses demonstrated that they understood certain aspects of the Islamic religion. This was illustrated by what they said and how they provided care. However, this evidence demonstrating understanding was not as strong as the evidence that revealed that the nurses did not understand aspects of the Islamic religion, or were confused about certain patient behaviours. A number of nurses were not able to distinguish whether certain issues were related to culture or religion. The literature

establishes a strong interconnection between culture and religion (Bonney, 2008 Hammoud et al., 2005; Tervalon & Murray, 1998), particularly amongst Arabs in Saudi Arabia (Al Shahri, 2002). According to Al Shari (2002), Saudi culture and health-related Islamic beliefs and practices are deeply interconnected. For example, Arab culture focuses on cleanliness, modesty and gender-specific needs. These beliefs exist in the Islamic religion because they inspire Muslims to clean themselves five times a day. Islamic teachings also strongly focus on respect for women. All these aspects need to be considered when caring for Saudi patients and families. Luna (1989, 1995) suggests that cultural care studies of the Arabs has led the way of understanding Arab gender differences relating to nursing care. Understanding these issues may foster the provision of culturally congruent care for Saudi citizens by non-Muslim health professionals.

The literature demonstrates that not only are nurses confused between religion and culture, but local people in different communities are confused about the differences between religion and culture. This was because people of different religions have cultures and traditions inherited from past generations. Converts are still living in their traditional cultures and contexts, but, to a large extent, are affected by religion. For example, the majority of Pakistanis are Muslim, but their traditions relating to marriage have remained unchanged and still share ancient Indian traditions (Bonney, 2008). According to Cook (2004), religions spread through several nations, leaving their cultures unchanged, and in their original socio-cultural environment. However, the word 'tradition' is neither static, nor unchangeable, but can be localised. The nurses in the present study noted that some women wore the hijab (head scarves) and others wore burqas, particularly when a male nurse or doctor was in the room. This was, in fact, due to their culture rather than their religion. Bonney (2008) notes that women in Afghanistan wear burqas, while the majority of women in neighbouring Pakistan do not. This has led to confusion between traditions rooted in local culture and religious requirement. For this reason, the distinction between religion and culture is not always observed.

As discussed above, the nurses tended to demonstrate confusion between religion and culture. Nurses frequently attributed aspects of their experience to culture particularly when, in fact, was due to religion, or they acknowledged that they understood the difference between religion and culture. Nevertheless, this highlighted the fact that there were a number of issues related to the differences between religion and culture which needed to be addressed, particularly due to the fact that this study focuses on the issue of religion related to the

nurses' experience of care. Religion was not the only feature of the experience. Saudi culture featured significantly, although the nurses often confused this with religion. The nurses in this present study had not fully realised the critical role of religion in the daily life of Muslims. Islamic teachings represented in the Quran and the Prophet Moh'd Sunaa are regarded as the main pillars of faith for Muslims worldwide. However, Muslims still confuse religion and culture, and at times do not distinguish between the two. According to the literature, there are differing views concerning the integration of, or distinction between, religion and culture. There also exist a number of religious dimensions in cross-cultural empirical research (Tarakeshwar et al., 2003). Jahangir et al. (1998) found that religious Afghani are less likely to commit suicide, due to the fact that they believe it to be forbidden by the Islamic religion. These results are in line with Vohra and Broota (1996), whose study found that religion was a resource for patients in dealing with stressful life conditions. The second dimension of religion is its cross-cultural aspect. Schwartz and Sagive (1995) have demonstrated that the value of spiritual life is closely connected to the cultural traditions of Muslim and Catholic teachers. It can be said that Islamic teachings are, to a large extent, conservative and supported by the conservative Arab culture inherited from past generations. According to Wikan (1988), cultural forces can affect faith and belief, as well as religious practice. Wikan studied two Muslim communities in Egypt and Bali. The author reported that when a child died in Egypt, their death created intense emotional reactions, while in Bali the reaction appeared calm, and thus concluded that the local culture differed in both countries, and religion was filtered through culture. It can be said that Islamic religion can take different shapes according to local culture. According to Roccas and Schwartz (1997), dynamic cultural factors play an important role in shaping the connection between individual and community values and religion. Stone (2002) states:

*Islam has adapted itself to local cultures and conditions, and its salience in politics derives to a considerable extent from this adaptability, rather than its ability to transform local cultures into any unified world image. Even while owing allegiance to the Islamic pillars and sharing a commonality of attitudes and outlook (which such allegiance is susceptible of enforcing) the adherents are willing to continue this allegiance only to the extent that it does not threaten their cultural autonomy. (p. 124)*

It can be concluded that there are challenges in providing healthcare to patients from different cultures and religious backgrounds. Nurses' understanding of cultural and religious

perspectives is therefore essential, particularly as this is critical when providing culturally competent healthcare (Hammoud et al., 2005).

As noted above, there exists a strong connection between culture and religion in the Arab world. Al-Shari (2002) has therefore presented an overview of Saudi culture, sub-culture and health-related Islamic beliefs and practices, in order to foster the provision of culturally congruent care for Saudis by non-Muslim health professionals. These beliefs included cleanliness, modesty and gender specific needs, which need to be considered when caring for Saudi patients and families. It has been suggested that studies in the culture of care for the inhabitants of Arabic countries has led to an understanding of Arab gender differences related to nursing care (Luna, 1989, 1995).

## **5.4 Cultural Competence**

This section discusses the ways in which nurses' awareness of cultural competency affected the provision of healthcare to Muslim patients.

### **5.4.1 Cultural Competency in Health Care Services**

Cultural competence is one of the main themes addressed in this study, along with its effect on the provision of healthcare by non-Muslim nurses to Muslim patients. The relationship between religion and culture has already been discussed, and therefore the discussion in this section is focussed on cultural competence and professionalism.

Cultural competency is an important aspect of the communication between patients and nurses, as an inability to communicate with patients can compromise care, rendering it inappropriate or inaccessible (Gravely & Boyd, 2001). When a patient is able to communicate what is wrong, the patient benefits and health outcomes are not compromised (Folts-Gray, 1998). The results of this study demonstrate that the participating nurses were not fully competent in communicating with Muslim patients, due to a language barrier and a lack of awareness of Saudi culture and values. It took the nurses a long time to understand parts of Saudi culture and they tended to struggle to apply this understanding in their provision of care. The nurses made very little reference to their own culture, and made no specific acknowledgement that they possessed a set of cultural values and beliefs that could affect the way in which they perceived Saudi patients. Although the researcher attempted to

obtain information concerning the nurses' cultural backgrounds, they generally focussed on the ways in which their culture differed from Saudi and Islamic cultures. The researcher's own university studies while training to become a nurse included different types of cultures in other parts of the world. According to Papadopoulos et al. (2004), cultural awareness is the first stage of the model and has been defined as the examination of one's own values and beliefs. An acknowledgement of this fact enables an individual to understand that cultural background influences perception of health beliefs and practices. The vast majority of nurses in the world are taught what is termed the 'medical model', which places emphasis on the causes of diseases and scientific treatments. Courses also cover nurses' previously acquired religious values and beliefs, and different types of religions worldwide (Galanti, 1991).

The Royal College of Nursing (2003) has acknowledged the change in the patterns of nursing as a result of nurses moving from one locality to another, which is intimately related to cultural changes affecting the provision of patient care and services. This cultural change relies upon communication between nurses and patients, and could be improved if both doctors and nurses were able to bridge the gap between the culture of medicine and the religious beliefs and culture of patients. This would then lead to a recognition of a patient's value system, including such aspects as religion, socioeconomic status, family origin or ethnic heritage. Each doctor and nurse has an opportunity to have a positive impact on a patient's quality of life (The American College of Obstetricians and Gynaecologists, 2011), and therefore nurses can maximise healthcare by learning more about their patients' religion, belief, spirituality and local culture. Furthermore, the cultural competence of a health care provider depends upon an awareness of his or her existence, sensation, thoughts and environment, without allowing these factors to have an undue effect on patients. Cultural competence is the adaptation of care in a manner that is consistent with the culture of the patient and is, therefore, a conscious, non-linear process (Purnell, 2002). Pino et al. (2013) conducted a study on the relationship between nurses and Moroccan patients in southern Spain, establishing that, in theory, cultural competence was able to improve patient outcomes and satisfaction.

The results of this current study demonstrate that, to a large extent, nurses felt some degree of culture shock when they began working in the hospital. As discussed in the section on religion, nurses were not fully aware of the Islamic teachings practiced by Muslims (e.g. prayer and fasting in Ramadan). The nurses stated that they had understood before coming to Saudi Arabia that it was a very strict conservative society, whereas, in reality, there are

varying degrees of conservatism in existence. The nurses' background knowledge of Saudi society could therefore be considered as stereotyping. For this reason, they were shocked by what they considered to be extreme practices. Culture shock is experienced differently by each individual, and consists of a mixture of anxiety and feelings of confusion, excitement and insecurity. Working in a completely unfamiliar environment leads to various challenges, one of which is dealing with culture shock, which is considered to be a major issue for foreign healthcare professionals when they settle in a foreign country. Culture shock relates to the emotional and psychological factors leading to confusion, uncertainty, clashes and certain unidentified reactions that affect an individual's observations and their interaction skills within different cultures (Black & Mendenhall, 1990; Campinha-Bacote, 1999).

The non-Muslim nurses working in different locations and hospitals in Saudi Arabia took a considerable amount of time to understand Saudi culture and religion. A number of researchers have emphasised that the provision of culturally competent healthcare can take a long time, i.e. until the foreign nurses acknowledge and understand the local culture (Benkert, et al., 2005; Johnstone & Kanitsaki, 2009, pp. 408). Benkert et al. (2005) stress that, in order to absorb it, nurses need to strive to become more attentive toward the diversity of the culture in which they are living. Nonetheless, Johnstone and Kanitsaki (2009) suggest that nurses and other health workers are not required to blindly accept other cultures, particularly ones that cause them harm. This is due to the fact that culture changes according to people's practices and realities.

#### **5.4.2 Training and Orientation of Saudi Culture and Religion**

This study has revealed that there was a lack of understanding of the principles of transcultural care, or that the nurses understood these principles to a certain extent but did not feel they were readily applicable for a country in which religion dominates all aspects of life.

Although it is easy to blame the nurses themselves for not being fully educated in transcultural care, they themselves reported that they had made every effort to learn about Saudi culture before arriving in the country. They also observed that there was no training and orientation specifically related to providing culturally congruent care in Saudi Arabia. This is an indication that they were aware of the importance of transcultural nursing, along with the fact that they were entering a country that was religiously conservative, and that this would impact upon care provision. This acknowledgement was further evidenced by the nurses' desire to gain information prior to their arrival in the country, and from their

colleagues once they had arrived. Purnell (2005) states that nurses progress from being unconsciously incompetent to being consciously incompetent, i.e. when a nurse is unconsciously incompetent they are unaware that they lack the required knowledge of another culture, and when they are consciously incompetent they become aware of their lack of knowledge. The findings of this current study demonstrate that, from the beginning, the nurses were consciously incompetent. This is also evidenced by their clear criticism of the training, which they felt was insufficient for nursing in a Saudi hospital.

It must be concluded that the institution itself has to bear some of the blame for problems arising from non-Muslim nurses caring for Muslim patients. This is evidenced by the fact that the nurses place a high value on their own professionalism, and demonstrated initiative in learning the language, culture and religion when they were not provided with adequate training in these areas. At the same time, the patients, too, held a high opinion of the nurses' professionalism. Hence, there was clearly inadequate training, as stated by all of the nurses interviewed. Waite and Calamaro (2010) state that the institutional climate is a factor that can have an impact on culturally competent behaviour.

The majority of nurses felt strongly that the hospital is partly to blame in this area, due to the fact that it has neglected the necessity for nurses to be given Islamic and Saudi-specific knowledge, because they are routinely expected to treat the native Muslim population. Indeed, it is evident from this study that the majority of the problems faced by nurses could be addressed by appropriate training and orientation designed specifically for the Saudi context.

When the nurses discussed religion as an aspect of the experience of caring for Muslim patients, they tended to focus on religious practices (i.e. practical aspects) and there was very little acknowledgement of spirituality. Moreover, where nurses did consider the religious needs of patients, it was their practical needs that were accommodated. This highlights the distinct lack of discussion on the part of the nurses regarding the spiritual aspect of the patient's needs. The only consideration mentioned by the nurses was that patients were more comfortable when nurses said 'Bismillah' (In the name of God) when administering medicine. There was no evidence that the nurses were proactive in considering spiritual needs. This was a concern for some of the patients, who stated that they would prefer Saudi nurses, due to the fact that they would understand their spiritual needs.

This raises a question about the concern of the nurses in this study to provide religiously congruent care in terms of spirituality, compounded by the fact that the nurses felt that religion should not have an impact on care and professionalism alone is required. This is supported by studies in the UK and the US that have demonstrated that nursing skills have been largely inadequate in terms of spirituality (Narayanasamy and Andrews, 2000).

The concept of cultural competence in a hospital setting implies that nurses should be able to understand the religious or cultural needs of those different from themselves. Education and training for cultural competence is aimed at nurses who care for people of other cultures and religions. This indicates that either: (1) the nurses had very little in the way of education and training for cultural competence; or (2) that in Saudi Arabia religion and culture are so important that any standard education or training would be insufficient. Ross (1997) suggests that, due to the definition of nursing, and the reality that an individual's health will depend on spiritual wellbeing, nurses should not disregard spiritual care in carrying out their duties. Moreover, the importance of providing spiritual care is a responsibility cited in national (UK) and international codes of conduct (Ross, 1997). It may be the case that in a Western context it is easier for nurses to adhere to these codes of conduct, due to the decreasing role of religion (Paley, 2008), and the fact that religion does not permeate every aspect of life. Such codes are concerned simply with respecting a patient's spiritual beliefs, allowing them to attend a place of worship, liaising with clergy and making arrangements to receive sacraments (Ross, 1997). However, it is clear in the present study that, due to the Saudi context, the provision of spiritual care requires greater consideration.

Despite the fact that the nurses accommodated religious practices, the patients were not entirely happy with the ways in which nurses met their practical needs. The most prominent example of this was ablution: a number of the patients said that the non-Muslim nurses did not perform this correctly for the patients, as they did not fully understand the requirements (i.e. if done improperly it is not valid and neither is any subsequent prayer). This led to patients stating that they would prefer Saudi nurses. This study revealed that many of the patients noted that Saudi nurses were often better in observing needs represented by religious practices. Leever (2011) argues that patients are strongly committed to their cultural values and cites this as one of the justifications for honouring such values.

This study observed that training and orientation were very poor in quality, both before arriving in the country and upon arrival. There were two phases to training and orientation:



The first phase was provided by the recruitment agencies and included aspects of religion and culture, albeit very limited and not specific to the Saudi cultural context. The second phase was provided by the hospital itself, with a focus on the Arabic language and hospital procedures, with religion and culture only mentioned in terms of the fact that Muslims pray. The nurses felt that in both cases the training and orientation was very limited, and that what they actually needed was information specifically targeted to nursing care for Muslim patients.

This finding is consistent with a study conducted by Luna (1998), which has addressed this issue within the same hospital. At the time the study was undertaken, in 1998, nurses were given a general orientation and introduced to the idea of transcultural nursing during their first two weeks at the hospital. They were also informed about courses available throughout their tenure. After three months (i.e. when nurses were expected to have encountered culture shock), they were offered educational programmes focusing on ‘cultural care adjustment’ (Luna, 1998, p.10). However, according to the participants in the present study, currently only general orientation short courses are provided, covering mandatory computer-based training, cultural awareness and sensitivity and working in a multicultural environment (AL hunidi, 2012).

Further evidence of orientation confirming the general cultural orientation expressed by nurses in the present study is provided by Aboul Enein (2002), who established that expatriate nurses at KFSH&RC were offered orientation seminars that helped them in understanding family dynamics. In contrast, this situation is not consistent with the picture illustrated by Luna (1998), who indicates that in-depth training and orientation were provided at the hospital, and discusses the challenges of designing programs in KFSH&RC. In addition, she refers to the fact that Leininger’s theory of Cultural Care Diversity and Universality was applied as a practical guide for education and clinical practice within the multicultural setting. Moreover, transcultural care principles were included as an aspect of the professional practice model, leading to culture being included in all programmes including cultural diversity workshops and transcultural nursing courses.

This present study finds no evidence of this level of planning and consideration, or of the delivery of such programs. When the nurses discussed training and orientation it appeared to be basic and ineffective and made no connection between cultural and religious diversity and providing culturally congruent nursing care. Given the considerable amount of attention that

has been given to transcultural nursing and culturally congruent care, it should be clear to the institution that this needs serious consideration when employing nurses from a different cultural backgrounds placed in a Saudi hospital. Moreover, in referring to orientating migrant nurses, Cowan and Norman (2006) suggest that there needs to be a focus on the nursing process in the host country. Although there were complaints concerning the lack of training in this current study, it cannot be considered a demotivating factor, as evidence given by both the nurses and patients demonstrated a commitment to developing personal skills in relation to both religion and culture. Van Rooyen et al. (2010) recommend that expatriate nurses in Saudi Arabia should not only familiarise themselves with Muslim practices, but also with religious restrictions.

The majority of nurses demonstrated an understanding of the importance of learning about Saudi culture as a component of their role as nurses. Both prior to coming to, and while working in, the country, they made a conscious effort to learn about the culture, particularly from their colleagues. This determination on behalf of nurses is supported by the study of Sidumo et al. (2010), which established that 90 percent of non-Muslim nurses wish to learn about Saudi culture and healthcare practices and beliefs. In addition to the training that was provided, many of the nurses made it their goal to learn about Saudi culture, with a number recommending that any nurses who intend to come to Saudi Arabia need to first learn about the culture, customs and traditions. This demonstrates that the nurses were aware of the fact that they knew little of the culture and healthcare beliefs of Saudi patients. This is supported by Sidumo et al. (2010), whose study concluded that a majority of nurses working with Saudi patients had limited knowledge of Saudi culture and healthcare beliefs and practices. This is a reflection of the fact that the nurses were highly conscious that cultural concerns were a characteristic feature of care in Saudi Arabia and that, as such, it impacted upon their role as nurses. It is also noted by Priestly (2000), in reference to Western nurses in Saudi Arabia, that it is better to learn about culture when living among the population, as this will assist an individual to become more culturally sensitive and improve their relationships. However, Bozionelos (2009) disagrees, stating that cross-cultural training has no real relationship with success in the workplace for expatriate nurses in hospitals in Saudi Arabia, due to his opinion that successful job performance does not require substantial cultural competence.

The self-motivation and initiative demonstrated above is in contrast to a study by Al Ahmadi (2009), who noted that many nurses (94 percent of the sample were expatriate non-Saudis) lacked the ability to improve their personal skills and work methods, either because they did

not have sufficient motivation, or because they were provided with little opportunity to improve skills and competencies. This represented a climate that lacked professionalism and did not stimulate ambition. Moreover, Luna (1998) states that there are barriers to transcultural education. These include the nurses' inability to accept cultural differences and the use of transcultural nursing concepts in practice, due to poor transcultural nursing education, or little pre-departure orientation. Luna cites factors external to the hospital for the nurses 'varying capacities to accept cultural differences' (Luna, 1998, p 10). However, in the present study the responsibility for the failures were established to be with the hospital rather than with the recruitment agents or prior nursing education. An explanation of this issue has been provided by Aboul Enein (2002), who notes that nursing education is controlled by two ministries in Saudi Arabia (the Ministry of Education and the Ministry of Health) and that there is very little communication, coordination and collaboration between them. Moreover, the problem is further compounded by the fact that there exists no formal nursing body to provide input into nursing education in the Kingdom.

In addition to the complaints of the nurses regarding insufficient training in relation to religion, culture and language, this study has established that the majority depended on their colleagues for information concerning these areas. Van Rooyen et al. (2010) found that expatriate nurses form support systems to assist them in dealing with cultural difference, and this provides a necessary lifeline in facilitating cultural adaptation. Moreover, Romas and Sharma (2004; cited in Van Rooyen et al., 2010) state that there are four types of support system: (1) emotional; (2) instrumental; (3) informational; (4) systems providing positive feedback. The results of this current study reveal that the support system in use was informational, i.e. support from colleagues came in the form of providing information to new nurses concerning how they should behave, along with general information concerning religion and culture in Saudi Arabia. Bozionelos (2009) found when studying expatriate nurses in Saudi Arabia that interpersonal ties with peers were a powerful resource. Throughout my study, dependency on peers was found to prevail in relation to religious, cultural and linguistic issues. Hence this study reveals that the nurses were significantly more dependent on their own working experience and the knowledge obtained from others, rather than on knowledge acquired through training and orientation. Papadopoulos (2003, p.5; cited in Papadopoulos et al., 2004) states that cultural competence is: "the synthesis of a lot of knowledge and skills which we acquire during our personal and professional lives and to which we are constantly adding", i.e. that knowledge and skills are acquired through work

experience as well as formal training. However, in this current study the greater dependency on work experience in Saudi Arabia highlights a serious deficiency in the promotion of cultural competence through training.

Immersion in a culture does have a number of benefits, and has been an approach employed in transcultural nursing education over a long period of time, as students gain a positive attitude towards the people of a particular culture if they are exposed to that culture (McGee, 1994). This is supported by Leininger (1994), who states that contact with other cultures promotes understanding concerning the similarities and differences between one's own and the new culture. This was true for the nurses in the current study, who (even though such exposure was not part of a formal training process) overcame the cultural shock of working in a Saudi hospital to understand more about Saudi culture. However, in contrast with McGee's (1994) study, the evidence from the present work suggests that this has not resulted in a positive change of attitude towards Saudis, particularly in the case of hospital staff and patients' families.

One explanation for the apparent decline in the quality of training and orientation in the hospital, is high employee turnover. Brown and Busman (2003) suggest that high turnover rates amongst expatriate nurses in a large hospital in Riyadh cost the hospital money, and (more importantly) contributed to a loss of productivity during orientation periods. However, there was no evidence in this current study to suggest a high turnover. In contrast, turnover at KFSH&RC is low, due the fact that the hospital offers a better employment package than other hospitals in Saudi Arabia, and therefore, a number of the nurses had been at the hospital for a considerable length of time. However, expatriate turnover of nurses in Saudi Arabia is generally very high, with one of the nurses in this study (Nurse 3) estimating that for every 500 nurses who arrive in the country, 300 leave due to being unable to adapt to the culture.

The need to develop cultural competence through an improved education program has been clearly highlighted in this research, despite the fact that the non-Muslim nurses in this study were able to gain an understanding of the culture from their peers. Educational intervention has a positive impact on health care professionals' understanding of the health beliefs and practices of a cultural group, a requirement of achieving cultural competence (Lee et al., 2006).

### **5.3.4 Developing cultural competence**

One of the main contributions of this present study is to assist develop and promote culturally competent care for the Saudi context. The Papadopoulos, Tilki and Taylor model has previously been used for developing cultural competence, as well as to contributing to models for assessing cultural context. The findings of this current study can be examined in light of this earlier model, along with the views of a number of further researchers concerning the achievement of cultural competence. This will assist in gauging the level of the cultural competence of the nurses in this study, identify shortcomings and provide a basis for proposing a means of rectifying the issues in the recommendations for future practice. In order to achieve cultural competence, the following four areas need to be achieved in succession.

#### **5.3.4.1 Cultural awareness**

Cultural awareness is the first stage of the model and is the examination of an individual's own values and beliefs. Once these are recognised, the individual is able to understand that cultural background forms part of their perception of health beliefs and practices Papadopoulos et al. (2004). In the current study, the nurses made no specific acknowledgement that they possessed a set of cultural values and beliefs that could affect the way in which they perceived Saudi patients. On the contrary, the nurses made very little reference to their own cultural beliefs when discussing culture shock, or perceived extreme practices in relation to religion. Furthermore, there is a need for the individual to be aware of his/her own bias, including stereotyping, making generalisations and racism (Dudas, 2012). There was evidence that the nurses made generalisations, as a high proportion stated that prior to coming to Saudi Arabia they assumed it was a very strict conservative society, whereas in reality there are varying degrees of conservatism. However, this was the only evidence of stereotyping and generalisation. Campinha-Bacote (1999) points out that self-awareness involves an examination of one's own bias and prejudices toward another culture. This self-awareness should be in-depth, and there is a danger that nurses could impose their culture on the patients. However, self-awareness is only the first stage in achieving cultural competence and there is a need to develop other areas of cultural competency (Campinha-Bacote, 1999).

#### **5.3.4.2 Cultural knowledge**

Cultural knowledge is concerned with understanding the world view of another culture, so allowing an individual to understand a client's behaviour (Campinha-Bacote, (1999). This study does demonstrate that the nurses already have a level of general knowledge concerning Arabic culture generally, although not of Saudi culture specifically. This was evidenced by the nurses' own efforts to learn about Saudi culture before they arrived and their acknowledgment that they understood Saudi culture to differ from other Arab cultures. Additional evidence concerning the fact that the nurses lacked knowledge of Saudi culture was their evident culture shock, particularly in relation to religion. The nurses in this current study did learn from interacting with their patients and made their own efforts to learn about the culture. However, there was no evidence that they understood the world-view of the patients. It should not be the sole responsibility of the nurses to acquire this cultural knowledge, it should instead be acquired through an official program of education.

Cultural knowledge can be gained by interacting with different ethnic groups. This assists in increasing understanding of different health beliefs and problems encountered (Papadopoulos et al., 2004). There was evidence that increased experience of nursing in Saudi Arabia led to a greater understanding of the culture, as the nurses who were relatively new at the hospital tended to depend on the more experienced staff, particularly in relation to the religion and culture of patients.

#### **5.3.4.3 Cultural sensitivity**

This section of the cultural competence model suggests that it is necessary for interpersonal relationships to be developed with clients, who should be viewed as true partners. This is due to the potential for nurses to abuse their power and so be unable to provide culturally sensitive care. Moreover, it is necessary for the relationship between the nurse and patient to include trust, acceptance, respect, facilitation and negotiation (Papadopoulos et al., 2004). In relation to these requirements, the nurses in the current study could, to a certain extent, be considered as culturally sensitive, due to the fact that (as attested to by both parties) there was a positive relationship between the nurses and patients. There was also evidence of trust and respect between nurses and patients; this was particularly so for those patients with no doubts concerning the nursing ability of the nurses. However, such trust on the part of the patients only existed to a certain extent: their trust was also placed in Saudi or Muslim nurses, due to the fact that they understood their religious needs.

When it came to issues of facilitation, the nurses demonstrated that they facilitated religious practices, although (as it has been noted previously) they felt that such practices were an impediment to care and at times the patients complained about the nurses' ability to accommodate these practices (e.g. ablution).

An important aspect of cultural sensitivity concerns communication. This can lead to misunderstanding if not undertaken effectively, particularly when such communication is made across a cultural boundary (Papadopoulos et al., 2004). These cross-cultural communicative skills include cultural communicative competence and intercultural communication (Papadopoulos et al., 2004), along with a need to understand community languages (Gerrish et al., 2004). In relation to the former, the nurse is required to learn details concerning the culture, its patterns of behaviour and the protocol that needs to be followed when interacting with people of a specific culture. Such knowledge will enable the nurse to understand the patient (Papadopoulos et al., 2004). In the present study, the nurses did take the initiative in attempting to adapt to Saudi cultural values and patterns of behaviour. However, due to the fact that they were frequently perplexed and made complaints concerning the behaviour of patients, it was clear that they had not acquired sufficient knowledge to understand their patients. On the other hand, this did improve with time and experience. Moreover, it is important to note that it was not entirely clear if the nurses' prior education and experience contributed to their cultural communicative competence. However, it was evident that their training and orientation both before, and upon arrival, at the hospital was not helpful in this respect.

Papadopoulos et al (2004), state that intercultural communication is the ability to recognise the difficulties that can arise when communicating across boundaries, including when attempting to recognise and be aware of personal values and expectations. There is evidence in this present study that the nurses attempted this type of communication, particularly with the patients' families. Moreover, Culley (Papadopoulos, 2006, p.18) further states that a nurse should not make assumptions and therefore requires communication skills to determine which practices are important to patients. The nurses in this study did not demonstrate that they possessed this particular skill, as was evidenced in two ways: firstly, the nurses emphasised that professionalism was important, meaning that religion was not a factor and that they were simply professional nurses; secondly, the patients said they preferred Saudi nurses because they were more sensitive to their needs. This factor was recognised by a

number of the non-Muslim nurses, thus providing further evidence of the nurses' lack of consideration for both the religious and spiritual needs of patients.

Purnell and Paulanka (1998 cited in Papadopoulos, 2006) are of the view that communication skills include verbal language skills (ones lacking by the nurses in this study), and non-verbal communication skills (such as eye contact, the use of touch, distancing practices and body language), which were perceived as challenging for the nurses in this study. The nurses were required to consider all of these aspects. Despite their complaints concerning the need to take care about making eye contact and physical touching (a particular issue in a Saudi hospital), the nurses conformed appropriately. Therefore, it can be said that, in this respect, the nurses demonstrated cultural sensitivity. It is important for nurses to overcome stereotypes and gain sufficient prior knowledge to avoid both personal stress and offending patients, and this may have an impact on care (Cully, 2001, cited in Papadopoulos, 2006). In this study, the inadequacies of their prior knowledge contributed to the stress experienced by the nurses.

The issue of the power relationship, noted by Papadopoulos et al. (2004) (i.e. the healthcare professional being the more powerful due to their expertise in comparison to the patient, or belonging to a higher social class) is an issue that needs to be addressed in regards to cultural sensitivity. However, it is not entirely applicable to the nurses in this study, due to their lack of social status (evidenced by their experiences of being disrespected and denigrated, despite their medical expertise), which was appreciated by the patients.

#### **5.3.4.4 Cultural competence**

Cultural competence is the final stage of the cultural competence model, requiring a synthesis of the three previous stages. The skills that should be acquired by this stage are diagnostic skills, assessment skills and clinical skills. For the nurses in the present study, these skills were impeded by both cultural and religious factors. The fact that they were not able to overcome these issues suggests that the nurses had not yet achieved full cultural competence, and that this is an aspect that needs to be addressed in both education and training.

In addition to the focus on practical skills and the ability to assess needs, another important aspect at this final stage is the ability to recognise and oppose racism and discrimination (Papadopoulos et al., 1998). In this current study, the only apparent racism was from the patients and the hospital, and there was no indication or complaint that the nurses were racist or discriminatory. The findings demonstrate that the nurses were respectful towards the fact



that the patients were Muslim and there was no indication of any issue related to the race of patients. The nurses can therefore be seen as culturally competent in this regard.

### **5.5 Professionalism**

One of the main findings of this study was that a majority of the nurses spoke about their professionalism in relation to caring for Muslim patients. They were asked if the religion of the patient (i.e. Islam) had an effect on their ability to provide nursing care. In responding to this question, the nurses defended their professionalism by stating that religion bore no impact on their ability to provide care. It is important to understand that the findings demonstrate that there were two different reasons for this response. Firstly, (the most common reason) the nurses felt that they had the required nursing skills to care for patients and that religion was not a factor. This was in contrast to having the required cultural skills where consideration of religion is a factor in the ability to provide care. Evidence of this was found in the nurses' responses to this question, which included the following statements:

*I just know how to take professional care of my patients regardless of their religion ... as I said before, it does not matter whether I am taking care of a Muslim patient or a non-Muslim. Taking care of patients is a universal standard and we are respectful while taking care of patients, regardless of their religion or anything else.'* (FG1 N1)

*I also agree that the religion of the patients does not affect the level of care that we provide. We just take care of patient of every religion in a professional way, so the level of care is the same for all patients, whether Muslims or non-Muslims.* (FG1 N3)

*I do not judge patients based on their religion or culture, but I judge the patients based on their personalities and their behaviour towards me. So, there is nothing specific that can be said about patients of any religion.* (Nurse 4)

*It does not affect me, because for me it was no big deal taking care of Muslim patients. I believe care is the same for patients, whether they are Muslims or not.* (Nurse 5)

It is clear from the findings that many of nurses were referring to their professional nursing skills, which they regarded as sufficient to care for any patient of any religion, apparently disregarding the importance of religion and cultural competence in nursing. The second reason behind the response was that a number of nurses acknowledged that the religion of the patient was a significant factor in the provision of care, and that they felt they possessed the

required cultural competence to care for a Muslim patient. However, this was a minority opinion. Statements in response to the same question included:

*You only have to consider that they might need all kinds of things for their religion.* (Nurse 7)

*Yes I think it affects our performance. If you and the patient are not of same religion, you cannot understand certain things (for example, some foods are good for health in some religions and not in another), Therefore you are unable to understand what the patients believes about certain things.* (Nurse 3)

This initial response (made by the majority of nurses) was found to offer a defence of their professionalism, i.e. that they were able to provide care equally, regardless of the patient's religion, and that a patient's religion had no impact on care. However, it was later revealed by the nurses that religion was, fact, a significant factor, impacting directly on their ability to provide care, i.e. in their relationship with patients, their nursing practice and scheduling and workloads. The nurses complained that the patients' religious practices hindered care and resulted in a negative experience, and therefore was not conducive to the provision of culturally competent care.

There was little indication from the nurses that they viewed professionalism as including the provision of culturally or religiously congruent care. However, this does not mean that they did not consider the religious needs of patients: practical religious needs were considered, although other religious needs were only addressed superficially. An example of this was saying religious words. This finding is supported by Tilki et al. (1994), who note that the socio-cultural needs of patients are addressed only at a superficial level and nurses focus solely on such aspects as religious practices.

In relation to this defence of professionalism, there a debate in nursing whereby it is argued that nurses should adopt an approach that applies the insights of modern science on the one hand, and on the other that spiritual and religious theories should be considered (Hussey, 2009). However, it appears that, in defending their professionalism, the nurses in the current study neglected an important aspect of nursing professionalism, i.e. cultural competence. This is due to the fact that (as demonstrated above) they stated that the religion of the patient should not be a factor in the provision of care. A study by Wehbe-Alamah (2008) focussing on care practices for Muslim patients claims that healthcare professionals have a responsibility to provide holistic and culturally-specific healthcare and that they should not

ignore beliefs and practices, which should be incorporated into a professional care plan. Hence professionalism should include the ability to provide such care, raising the following question: Why is it that, despite the fact that many have Western nursing education backgrounds (where transcultural nursing is an aspect of curricula), do the nurses in this study view religion as an unimportant aspect of the care component of professional nursing?

Ohlen and Segesten (1998) have established that certain personal attributes of the professional identity of a nurse need to be considered. These include compassion and conscience, as well as competence. However, in this present study the nurses placed emphasis on competence alone as an aspect of their professionalism. They were assertive and had a strong self-image, which leads to a nurse retaining a sense of professionalism even when their role collapses (Öhlén and Segesten, 1998). In the present study, such a collapse would involve a change from their customary role to one that involves accommodating religious needs, and therefore would affect their role in a number of ways, i.e. becoming prayer facilitators. Tilki et al. (1994) state that any perception that a patient's culture is unfamiliar, problematic or of little interest will result in inferior healthcare. This is also supported by Stranahan (2001), who notes that if nurses' own spiritual care practices are neither positive nor essential, then negative practice will develop. However, the patients in this study also defended non-Muslim nurses' professionalism and stated a general satisfaction with the quality of nursing care provided. This was maintained even with the apparent lack of consideration of spiritual and religious needs (an aspect also emphasised by the patients): professionalism, or at least the image of professionalism, still stood.

It may prove to be that the confusion established in this research between professionalism and culturally competent care is a misunderstanding of the difference between culture-specific care and culture-generic care put forward by Gerrish and Papadopoulos (1999). The nurses may have felt that they have received sufficient transcultural training throughout their career to enable them to provide culturally congruent care. However, this transcultural training (particularly at KFSH&RC) was culture-generic, as evidenced by the nurses' responses. This may explain their defence of their professionalism, i.e. they feel capable of providing care due to having received culture-generic training for Muslims in general. However, the findings reveal that in Saudi Arabia there is a real need for culture-specific care.

Although this study focuses on the experience of the non-Muslim nurses, in discussing the relationship between nurses and patients and the role played by religion, it has been necessary

to also consider the views of patients. The patients initially appeared to agree with the nurses that religion has no effect on care, and (again similar to the opinions of the nurses) there was a defence of the nurses' professionalism. The patients emphasised that they appreciated the care that they received from non-Muslim nurses, often comparing their professionalism to Saudi nurses, who were viewed as being less professional. This trust in the professionalism of Western nurses is supported by Walczyk (2006), who states that Arabs place a high value on Western medicine and have confidence in treatment from Western medical professionals. However, all of the patients (as with all of the nurses) eventually revealed that religion was a factor in the nurse-patient relationship, and that non-Muslim nurses lacked an understanding of the patients' practical and spiritual religious needs in comparison with Muslim nurses. Walczyk (2006) also found that, despite the high regard for Western medicine, Muslim patients will always see the reason for the disease in relation to religion. Their cure (along with their general health) is also seen to depend on comprehensive, spiritual and holistic care. Support for this idea lies in the fact that the majority of patients interviewed said they preferred Saudi nurses because they understood their spiritual needs, as well as their religious practical needs (i.e. being properly cleaned for ablution). Aboul Enein (2002) perceives an assumption that when an expatriate nurse arrives in Saudi Arabia with the required expertise, they may not have the skills necessary to provide culturally congruent care to Muslim patients. In this present study, a distinction was clearly made by both nurses and patients between (1) professional nursing care and (2) professional nursing care with cultural congruency. The patients did not criticise the non-Muslim nurses' level of care, however some of the non-Muslim nurses (contrary to their defence of their own professionalism) understood that a Muslim patient's religious and spiritual needs could be better met by a Saudi nurse.

#### **5.4 Language**

Communication between health care providers and patients and their families is consistently identified as the most important and least accomplished factor in quality of care (Bauman et al., 2003). The results of this present study indicate that language was one of the main barriers to the provision of health care to Muslim patients, due to the fact that the majority of non-Muslim nurses were unable to speak Arabic fluently. Over half the nurses who participated in this study reported difficulties when communicating with patients and relatives in the Arabic language. The nurses acknowledged the importance of language when

they first started dealing directly with patients and associated this language barrier with their inability to provide proper care. The results of this study were consistent with the results of El-Gilany and Al Wehady (2001), who emphasise in their own study that the language barrier was considered one of the main barriers to health care provision for Saudi patients in hospitals, due to the vast majority of nurses being unable to speak Arabic. In their study of nursing services in the United Kingdom, Carrasquillo et al. (1999) note that language problems increase the likelihood that patients would not return to the same medical organisation in the future. Al Mutairi et al. (2012) argue that the main consequences of employing non-speaking Arabic nurses is that they work for limited periods of time, which hinders communication with patients. Furthermore, in their study conducted at King Abdul Aziz Medical City, Al-Khathami et al. (2010) found that patients were concerned about the language barrier during the delivery of nursing care. The study results suggest that miscommunication between nurses and patients compromise the patient-nurse relationship. According to Easterby et al. (2011), the inability to communicate effectively leads to frustration for both nurses and patients, resulting in miscommunication concerning health conditions and medicine. More importantly, language problems form a barrier to providing culturally sensitive care. The ability to speak Arabic would enable the nurses to ensure patients comply with their regimen and explain why it is important. It has been demonstrated that there is a correlation between a language barrier and compliance with taking medication (Dived & Rhee, 1998, as cited in Aboul Enein & Ahmed, 2006).

Language issues also affected care and impeded the nurses' ability to perform their duties. Communication was particularly important for the nurses in order to provide care. The nurses stated that many of their patients were not compliant, and that being unable to speak Arabic led to an inability to explain the benefits of following their care advice. Axner and Dupraw (1997) found that the majority of nurses reported that a different language was perceived as a major barrier to giving the healthcare intended. The authors also indicate that false assumptions could easily be made during nurse-patient interaction when language was a barrier. The authors affirm that some of the assumptions could be appropriate, when they related to knowledge of the patient's language and culture. However, it is necessary for nurses to be cautious when generalising and making assumptions as a part of their assessment, particularly when an interpreter is available.

The results of the present study have established that the non-Muslim nurses had realised the importance of the Arabic language for daily communication with their patients. For this

reason, they intended to learn Arabic as soon as they began working. However, the hospital management provided them with insufficient language training courses upon their arrival to the hospital. The training courses taken by nurses were, in general, unrelated to their work in the hospital. This led the nurses to learn from their colleagues in the hospital, which proved to be insufficient. The inability to learn and understand Arabic leads to suggestions regarding hiring interpreters to assist in communicating with patients. Mateo et al. (2009) state that medical interpreters should be proficient in both local languages and English, understand medical terminology and, more importantly, understand general cultural issues (e.g. family structures and roles). An interpreter of the same gender is preferable, particularly when discussing sensitive issues and intimate subjects. David and Rhee (1998) found that a clear communication of medication instructions was of critical value in patients adhering to a regime of medication. The authors stress that language is a barrier that results in challenges when it comes to discussions between nurses and patients regarding medication, leading to a lack of explanation concerning potential side effects, and so having a negative impact on compliance. The patient-centred orientation of nursing makes it imperative for nurses to be able to respond to the unique cultural and language needs of patients (Retner, 2001). Timmins (2002) recognises the negative impact of language barriers on health outcomes, such as the potential to prescribe inappropriate medications. A study of hospitals in the United States conducted by Betancourt et al. (1999) demonstrated a relationship between issues of language and actual follow up of patients.

The results of the present study also indicate that nurses expressed their frustration in relation to the time wasted in attempting to understand patients' requests, which had a negative effect on the provision of high quality healthcare. Furthermore, the nurses were frustrated with interpreters unable to translate correctly, leading to them to rely on family members and relatives. According to Jacob et al. (2004), relying on family members and friends for translation frequently results in negative consequences and a lower quality of health care. These results are consistent with the results of a study conducted by Gerrish et al. (2004), which established that interpreters were unable to provide adequate translation services and that nurses were dependent on patients' family members and friends. The frustration expressed by nurses in this current study concerning the translation provided by interpreters has been addressed by Aboul Enein and Ahmad (2006), who emphasise that interpreters can provide inaccurate information to patients leading to a breach of security and confidentiality.

## **5.5 Social Aspect Related to Provision of Health Care**

This section discusses a number of different social issues related to the provision of healthcare, as reported by the nurses and patients. These include: family interference; respect and the role of nurses; emotional aspects of patients and nurses; gender issues related to male and female nurses.

### **5.5.1 Family Interference**

The focus groups and interviews conducted with nurses demonstrate that Saudi family members held the main control over all decisions related to patients. Bauman et al. (2003) cite evidence that the patient-centred approach leads to an increase in the following: patient satisfaction; engagement; task orientation; reduction in anxiety; quality of life; doctor satisfaction and efficiency, resulting in fewer diagnostic tests and unnecessary referrals. This implies that such positive results were found when family members were involved in all aspects pertaining to the main issues, such as diagnosis, medication etc., thus influencing the healthcare provided to patients and the confidential information held between the nurses and patients, as well as controlling the care regimen and medicine. Although family members interfered in the care provided, they believed they were acting in the interests of the patient. A study by Halligan (2006) also noted that the role of the family plays a significant part in the experiences of expatriate nurses in hospitals in Saudi Arabia, and could be an impediment when meeting the needs of patients. Furthermore, van Rooyen et al. (2010) state that expatriate nurses working in Saudi Arabia find it difficult to adhere to a routine and perform their duties, due to the fact that the patients' families control when these duties should be undertaken. Sidumo et al. (2010) note that 70 percent of non-Muslim nurses in their study found family involvement in the management of the patient to be a challenge.

The nurses stated that in Saudi Arabia the patient's families or sitters (a member of the patient's family who stays with the patient) had control over treatment and how the nurse managed the patient. They attributed this to culture and felt that it had an impact on their ability to provide care. An extreme example was that some of the nurses noticed that families controlled the information given to the patient, particularly in the case of bad news, when some families would insist that the patient was not informed of the diagnosis. This finding is in accordance with Halligan (2006, p 1568), who found that families in Saudi Arabia often 'dictate the care' and control the extent of care, often without the patient's knowledge, and

that this was a source of stress to the nurses. According to Al Shahri (2002), it is part of Saudi culture that it is the family who decide how much to tell the patient.

This study therefore agrees with the findings of previous researchers, as follows. Al Shahri (2002) has noted that an individual's autonomy is overruled by the authority of the family, and patients' decisions are often altered by the views of the family. Van Rooyen et al. (2010) observed that expatriate nurses in a Saudi hospital are unable to provide effective care due to patients and their sitters determining when nurses carried out their duties. Van Rooyen et al. (2010) examined patient advocacy in Saudi Arabia in depth, finding that it was the families who dictated important decisions regarding patient care, not the patient. This is also recognised by Walczyk (2006) who comments that the extended family holds a position of importance, and older male members have influence over health care decisions. The opinion of the nurses in this study is that the patient's family has too much influence and interferes too often. This concurs with a study by al-Mutair et al. (2012) conducted in two hospitals in Saudi Arabia, which concludes that the majority of the nurses in their study (most of whom were expatriates) were against the idea of patients' families being present during resuscitation, and they believed that their presence would not benefit the patients. Al-Mutair et al.'s (2012) study also finds that nurses feared that their performance would be negatively affected by the presence of family members, due to the fact that family members may react emotionally to nurses, who may feel threatened, so affecting their performance. In addition, there was also the issue of the physical impediment of large numbers of family members around a patient's bed, confirming the following findings: (1) Al Shahri (2002) is of the opinion that too many family members surround the bed in Saudi Arabia, interfering with the delivery of health care; (2) Halligan (2006) notes that the prolonged presence of patients' families is a 'nuisance' to nurses.

A further issue raised by nurses was communication with the patients and the effect of family members on communication between nurses and patients. The nurses reported that family members interfered in every single issue and did not allow the patient to put forward their opinions. In Saudi Arabia, family members, relatives and friends are an integral part of the patient's support system in their room. Therefore, communication is not always with the patient but the family members (Van Rooyen, 2010). According to Van Rooyen (2010), the presence of family members and friends in the patient's room hinders verbal and non-verbal communication with patients. Ross and Deverell (2004, pp. 29) define non-verbal communication as messages conveyed using body movements, specifically relating to



feelings and the intensity of emotions. These results accord with the findings of Halligan (2006, pp. 1568) who indicates that families in Saudi Arabia frequently ‘dictate the care’, controlling the extent of care, often without the patient’s knowledge. This proved to be a cause of stress for the nurses.

#### **5.5.2 Being a non-Muslim, female, expatriate nurse working in Saudi Arabia (lack of respect)**

The results indicate that the nurses who participated in this study felt that they were not respected by patients and families, due to the fact that they were neither Saudis nor Muslims. Furthermore, nurses imputed a lack of respect towards religion and Saudi local culture because they were female in a male dominated society. The nurses reported that they highly respected the religion of Islam and appreciated Muslims’ beliefs and faith, as reflected in their willingness to use Islamic phrases or supplications. However, although nurses respected the Islamic faith, some felt their feelings were not reciprocated, feeling under pressure to convert to the Islamic religion, and also subject to questioning about why they were not Muslims. Furthermore, nurses felt that they were not respected by religious police (Mutawwa) and were required to wear the hijab, even though they were not Muslim.

Nurses reported that their relationship with patients was, to a large extent, mutual when compared to their relationships with other healthcare providers. However, some dealt with nurses in different way. Nurses’ experiences were not always negative, with a number being well respected and welcomed by patients’ families, particularly in response to the high level of care that they were providing. These results were, to a large extent, inconsistent with the survey results conducted in the United Kingdom. MORI (2002) conducted a survey involving internationally recruited nurses. The results demonstrate that the family members of carers and patients did not respect the nurses and would often try to avoid them. The survey also found that family members reported problems directly to the manger. A survey on senior nursing officers conducted by the National Organisation of Nursing Executives (2003) found that these officers faced a lack of respect from patients, affecting their ability to innovate and develop new methods in order to improve patient care.

Saudi Arabia is a male dominated society, and this is clearly reflected in the nurses’ experiences. It is well known that the apparent subjugation and isolation of women in Muslim culture provokes criticism from non-Muslims as being an unacceptable part of that culture (O’Hagan, 2002). The nurses in this study provide their own evidence and examples of this

aspect of Saudi culture. This was particularly evident in their interactions with male doctors. Some of the nurses in the present study felt that they did not receive respect, or were not trusted, and that other members of staff were frequently rude to them. These nurses said that the reason for this was because they were female, and this lack of respect even extended to a lack of respect for their professional opinion by doctors. These gender-related issues affected the nurses personally and were seen as (in addition to gender) being an impediment to providing care.

The most notable problem was the attitudes of males, whether they were doctors, other hospital staff or patients. This attitude towards nurses may not have been purely due to the fact that they are female, but rather because they are working females. Saudi Arabia has a patriarchal, male-dominated society, where there is a perception that the male should be the main breadwinner (Elamin and Omair, 2010). Moreover, the review of the literature in the present study has demonstrated that, due to the cultural perceptions of women working, the nursing profession itself is not held in high regard, leading to the high dependency on foreigners in nursing. Elamin and Omair (2010, p 758) state that Saudi males believe themselves to be “dominant, independent, competitive and capable of leadership and women are submissive, dependent, caring and good for domestic tasks and child rearing”. The pervasiveness of this attitude is more prominent in Saudi Arabia, and a number of the nurses in this study made reference to the fact that Saudi Arabia was more conservative than the other Arab countries in which they had worked. This opinion is also supported in Elamin and Omair’s (2010) study regarding male attitudes towards working women in Saudi Arabia, where it is stated that women in other Arab countries have greater educational and employment opportunities available to them.

In a study by van Rooyen et al. (2010), some of the negative emotions experienced by expatriate nurses working in Saudi Arabia were feelings of discrimination and frustration. The nurses in this study also felt they lacked respect on a professional level, particularly the fact that doctors frequently ignored their medical advice in relation to patients. Van Rooyen et al.’s (2010) study noted that nurses felt they needed to prove their competence, and were not acknowledged on the basis of their previous experience, leading to feelings of worthlessness. The nurses often made comparisons with their home countries, where they were well respected as nurses and were not viewed as simply the hired help. Moreover, in their home countries there were specialist nurses to take care of cleaning the patients and that they viewed their own role as the First Nurse, responsible for medication only. In contrast, in

Saudi Arabia they were required to carry out all nursing related duties, which they felt was a further indication that they were not as well respected for being educated and experienced professionals.

There was one aspect of the nurses' experience that made them understand exactly what it means to be an expatriate nurse in Saudi Arabia, i.e. whenever there was a dispute between the patient and the nurse, the hospital always took the side of the patient. This was attributed by the nurses to the fact that they were not Saudi. This idea that being a Saudi makes the patient superior to the nurse was also expressed by the patients, who pointed to the fact that they are Saudi when nurses complained to them about their behaviour or not following medical advice. This admonishment was made in such a way as to put the nurses in their place. In one case, when a male patient was treating a nurse like a 'slave' the nurse resorted to calling security, who would then side with the patient.

The institution (i.e. the hospital) played its own role in the experience of non-Muslim nurse's caring for Muslim patients. This was mainly due to the corporate culture of the organisation, which the nurses felt was part of the overall culture pervading the country. The nurses complained that they were not respected and encountered negative behaviour from the institution itself, as well as from other members of medical staff and the patients. However, it was not apparent that this was related solely to the fact that the nurses were female (these issues were also expressed by a male nurse) or non-Muslim, as there was no evidence for the latter. The evidence did however support the perception that this sense of negativity and lack of respect came mainly from the fact that they were expatriate nurses and not Saudis. The nurses also attributed this fact to culture, with the interviews revealing, as discussed above, that the institution always sided with patients in disputes with nurses.

Moreover, some of the nurses said that they felt that they were not respected by hospital staff, with some feeling that their professional opinion concerning patients and their treatment was not respected by doctors. The latter point is addressed in a study by Brown and Busman (2003) which finds that, in the opinion of expatriate health workers, the health care system in Saudi Arabia is centred on physicians and is more authoritative than collaborative. This aspect is blamed on the cultural, social and historical factors in Saudi Arabia.

This left some of the nurses feeling that they were not respected professionally. An explanation can be found in Brown and Busman's (2003) study. They note that due to the fact that Saudi patients place an emphasis on surgery and medicine, and not so much emphasis on

rehabilitative medicine, they view the physician as the primary care provider and consider other health care professionals (i.e. nurses) as under the control and supervision of the physician. Thus, the expatriate health professionals may feel that they are only the 'hired help', and so will be less enthusiastic about their work. However, this present study contradicts Brown and Busman (2003) in one aspect: the patients in this study recognised and respected the nurses' professionalism, and it was the patients who were closest to the nurses and who had the highest level of respect. In contrast, it was patients' families, the hospital and hospital staff who made the nurses feel degraded.

In concluding this section about the ways in which the attributes of the nurses (i.e. being non-Muslim, female and non-Saudi) affected the nurses' experience, it is clear that there was an overall feeling of resentment relating to being disrespected. Based on a study by Al Ahmadi (2009), it was found that for nurses working in Saudi Arabia, job commitment, as well as job performance, was influenced by the following: relationships in the workplace; patient appreciation; and the respect received by nurses from physicians. Given that the nurses in this study complained, to a greater or lesser extent, about all these factors, a high turnover of nurses could be expected due to a lack of commitment to the organisation. However, at KFSH&RC (and specifically across much of the sample group) there was low employee turnover in comparison to other hospitals in the country. From the researcher's own experience as a nursing educator, this appears to result from the fact that the nurses at this hospital are remunerated particularly well. However, this also contrasts with Al Ahmadi's (2009) study, which found nurses were dissatisfied with their salaries.

This section has addressed the issue of disrespect for nurses personally and professionally and this study as a whole has revealed that there are a number of sources leading to this disrespect. These range from the institution itself, patients, patients' families and other hospital staff. In a study by Zakari et al. (2010), similar factors (such as the workplace and society's and consumers' (patients) views of the nursing profession in Saudi Arabia) were found to contribute to nurses' low perceptions of their professionalism. While Zakari et al.'s (2010) study might lead to an expectation that the nurses in the present work would have a lower impression of their professionalism, this was not, in fact, the case. The nurses in this study were assertive about their professionalism, and although they did say that religion, culture and other factors affected their work, in no way did this reflect on their perceived professionalism.

### **5.5.3 Emotional Aspects of Patients**

The study results demonstrate that female patients had no way of articulating themselves emotionally, and were only able to express their pain to gain attention. These results are in line with a study conducted by Lovering (2006), who found that, due to cultural factors, Saudi female patients were more likely to express pain verbally than male patients. Most emotional aspects experienced by the nurses were strongly aligned with the aspect of care that was deeply rooted in the patient's religion and culture, which made nurses feel powerless when they were upset and sad. Carayon and Gurses (2009) indicate that nurses feel that the care of Muslim patients brought them personal challenges, particularly in relation to their professionalism, adding that nurses feel frustrated and tense because they are dealing with patients from different cultures.

The results of this study also showed that some nurses had psychological symptoms that affected the proper delivery of healthcare. This was due to cultural problems faced in the hospital (e.g. family members' interference in decisions related to patients). It should be clarified that culture is learned and transmitted from generation to generation. In their seminal study, Miliki and Janiajervic (2009) state that culture is a combined setup of mind that creates values, attitudes and behaviour. Culture shock occurs in those who arrive in different kinds of environments and feel psychologically disordered, and generally occurs due to a lack of social feelings, familiar customs, signs and symptoms: i.e. what an individual is used to having has been taken away (Harrison, 1994).

### **5.5.4 Gender Issues in Providing Health Care**

It was found that a significant part of the nurses' experience was a concern about transgressing cultural barriers and being falsely accused of inappropriate behaviour, particularly in relation to being female and caring for males. This concern was reflected in the fact that the nurses felt that they had to be continuously careful about how they behaved, as they were wary of their actions being misinterpreted. The study results also demonstrated gender issues in the provision of health care to patients. It was shown that some male patients preferred their care to be undertaken by male nurses, leading to female nurses having to spend additional time looking for male nurses. While male nurses care only for male patients, female nurses care for both sexes, leading to female nurses being overloaded with additional work. Previous research has established a relationship between preference for a same-gender health care professional and situations that were "intimate in nature, requiring a patient to undress" (Ackerman Ross & Sochat, 1980; Kerssens et al., 1997). The literature reports that

prefer healthcare providers for matters of reproductive and sexual health, and especially for consultation regarding intimate or psychological issues (Brooks & Philips, 1996). Males also demonstrated a preference for a female nurse, but to a lesser degree (Kerssens et al., 1997). In his study on Muslim patients in the United States, Sengstock (1996) found that Muslim and Arab patients preferred female nurses. The study suggests that when this is not possible patients should be informed about this issue and asked to change their behaviour. From a women's point of view, this would help women to feel more comfortable. Researchers have also noted that patients value their nurses' technical expertise (Greenhalgh et al., 1998). It is plausible, therefore, that in situations where such expertise is required, a patient may have fewer concerns in relation to the gender of a nurse compared to situations requiring more intimate and psychological interaction. To date, only a small number of studies have been undertaken to address patients' preferences for the gender of nursing staff. While nursing is still generally perceived to be a feminine profession, a number of men also practice (Lodge et al., 1997). Thus, both male and female patients could encounter a nurse of their own gender, although female nurses are more likely encountered than males (Ekstrom, 1999).

#### **5.5.5 Female Patients**

The study results indicate that female patients were unable to make any decision related to medical procedures, leading to women having to rely on their husbands or any other relative, as these were responsible for all procedures. It could therefore be concluded that women were neither socially or economically independent. According to Al-Shahri (2002), women were happy to delegate signing the consent for medical procedures to their husbands or any male relative. From a gender point of view, women were sometimes exploited because they were economically dependent on their husbands (Kan, 2001). There is a view that an increase in women's economic resources increased the likelihood that men were abusive (Gibson et al., 2005), while Saudi females generally enjoyed a sense of social security provided by the family and male relatives. A study conducted by Leever (2011) on Middle Eastern women found that all medical decisions were made by husbands, particularly when women were in labour. These results were in line with another study conducted by Leever (2011), which found that decisions relating to women were made by their husbands. This was a cause of disappointment and frustration for physicians. McDonald and Bridge (1991) describe a study in which nurses were asked to draw up a proposed treatment plan on the basis of a care description that presented the same patients as alternately female and male. The nurses' care plans varied significantly in several points, depending on the patient's gender. Female

patients were less likely to have a plan to mobilise them, they received fewer pain killers and nurses allocated less time for emotional support when they thought they were planning for female patients. Further studies have demonstrated that male patients were given more post-operative pain killers than female patients, as women were assumed to have more complaints compared to men (Anderson et. al., 2000; Anderson et al., 2003).

There is, therefore, an opportunity to address the issue of gender in Saudi society, particularly when related to nursing. The demographic changes that have taken place worldwide have created diverse populations and an increase in population. Over the past four decades, Saudi Arabia has witnessed high population growth rates, leading to the need to build additional hospitals and healthcare facilities. Furthermore, nursing among Saudi women has been a less desirable choice in comparison to other professions, such as teaching. Studies have attributed the unwillingness of females to join the nursing sector to cultural factors, the type of work and long working hours (Tumulty, 2001). These features have made a considerable contribution to the reliance on foreign workers, with over two thirds of nurses in Saudi Arabia being expatriate.

#### 5.5.6 Women in Saudi Arabia

Doumato (2008) has stressed that women in Saudi Arabia have not gained a high level of rights within either the family or society. Their movements have been restricted, with little active participation in the economy. During the early era of Islam, Muslim nurses, were given positive images, however more recently there have been negative images of nursing as a profession for women (Sultan, 1990). These negative images have contributed to the shortage of female nurses in Arab culture in general and Saudi Arabia in particular (Boyle & Salman, 2003; Shukri, 2005). A study conducted by Al-Kandari and Ajoa (1998) on nursing programmes in Kuwait, found that issues relating to recruiting and retaining nurses was attributed to a belief that nursing was a disrespected and powerless profession. The results of this study are in agreement with El-Haddad (2006) and Okasha and Ziady (2001), who revealed negative attitudes towards nursing as a career. Alawi and Mujahid (1982) indicate that the majority of Saudi families do not regard nursing as an honourable occupational choice for their children. According to Alnaif (2011), Saudi nurses face a social stigma when working.

## **5.6 Workload, Stress and Patient Safety**

This section discusses the results revealed by nurses about their views on workload, stress and safety.

### **5.6.1 Workload and Stress**

The results of this study demonstrated a direct relationship between the practicing of Islamic duties by Muslim patients (e.g. prayer and fasting) and the workload of nurses. Nurses in this study reported a number of features that were related specifically to the context of caring for Muslim patients in Saudi Arabia, which the nurses felt made their working routine far busier and placed them under additional pressure in terms of their workload and scheduling. Reimer-Kirkham et al. (2004) have pointed out that a heavy workload for the nursing staff was attached to spiritual issues. It needs to be acknowledged that spirituality and faith cannot be separated from the provision of health care and should therefore be integrated into holistic patient care. Therefore, even if the workload is a burden to nurses, they need to consider it as part of their daily work.

It is also important to understand that a situation of stress and moderate workload can improve a nurse's performance and patients' quality of life, i.e. up to a point, stress, is essential and healthy because it challenges nurses. However, if stress and workload become excessive, it harms both patients and nurses (Makinen et al., 2003).

### **5.6.2 Patient Safety**

As noted previously, the study results indicate that communication was weak between nurses and other parties within the hospital, as doctors dealt with nurses in a disrespectful manner. Poor communication between different parties in clinical institutions affected patients' safety. According to Hughes (2005), communication between nurses and physicians, as well as relationships with patients, affects patients' outcomes and their safety. When professional communication takes place between nurses and other staff members, medical errors and adverse events decrease, and, consequently, ensure patients' safety.

The findings of this study also established that nurses had experienced additional workloads, resulting from their time being rescheduled. This affected the provision of care to patients, which may also create problems for the healthcare system in the hospital. Carayon and Gures (2009) state that nurses in American hospitals are overloaded with work, and this has negatively affected the provision of care. The authors attributed this to a number of factors,



including an inadequate supply of nurses, a reduction in patients' length of stay and reduced staffing. Lang et al. (2004) note that one of the main consequences of high nursing workload was an adverse effect on patients' safety. A number of research studies have investigated the effect of workload and linked nursing staffing levels to patient outcomes (i.e. failure to rescue) (Aiken et al., 1996; Stanton & Rutherford, 2004). Furthermore, Needleman et al. (2002) have indicated that a higher number of nurses working at one time correlate with lower rates of urinary tract infection. A further study conducted by Proovost et al. (1999) has demonstrated a relationship between patient outcomes and nursing staffing. The authors established that the 1:2 nurse-patient ratio during the evening shift correlated with an approximately twenty per cent increase in the length of stay in patients with complex problems with an abdominal aortic aneurysm.

## 5.7 Chapter Summary

This chapter aimed to discuss the main results presented in Chapter Four. The different sections of the chapter have presented, interpreted and discussed the findings from the empirical studies previously conducted by researchers. The discussion revealed that the study results were inconsistent. The results showed that there was a consensus among non-Muslim nurses concerning the impact of religious practices (such as prayer and fasting) on the provision of healthcare to Muslim patients. The study results also indicated that non-Muslim nurses understood the religion and culture of Saudi Arabia, but could not understand the importance of faith to Muslims, particularly in relation to recovery from illnesses. It was demonstrated that nurses had not developed a competent understanding of Saudi culture, which affected them both emotionally and professionally, and consequently, affected the provision of care. The study results demonstrated a lack of training and orientation for nurses on Saudi local culture, Arabic language and religious practices. It can therefore be concluded that the research objectives and questions stated in the introductory chapter of this study were achieved and answered.

## **CHAPTER SIX: LIMITATIONS, RECOMMENDATIONS AND CONCLUSIONS**

### **6.1 Overview of the Chapter**

This chapter presents the contribution of the study to knowledge in the area of transcultural nursing, and addresses the practical implications of the research findings for education and development. The chapter also presents the implications of the study for nurses and nursing practitioners, the other staff at hospitals in Saudi Arabia, those responsible for nursing training and education, and the wider community, including Saudi government policy makers. Moreover, the chapter also outlines the limitations of the study leading to proposals for future research.

### **6.2 Contribution to Knowledge**

A discipline is considered to have advanced when we have attained clearer ideas and understanding than was available in the existing body of knowledge. Therefore, the understanding of cultural and spiritual aspects in the field of nursing introduced in this thesis has increased knowledge in this area. The field of nursing research is very wide, and transcultural aspects are an important aspect of it. Many researchers have addressed Transcultural and spiritual aspects; however, former studies did not offer a clear depiction of the challenges encountered by nurses working within cultures that differ from their own, or of how they overcome them.

Nursing research has developed rapidly over recent decades; however, it has been questioned whether this increased study of clinical practice has produced knowledge of relevance to the work of clinical nurses and to the benefit of patients (Hallberg, 2006). As researchers and nurses, it is essential to consider carefully how the findings we report can be translated into practice. My study is original and has generated knowledge that can be applied to guide practice in the context of Saudi Arabia, and at the international level. In order to position my research, it is necessary to summarise what other empirical studies have determined about the relationship between provision of care and cultural issues including religion. Bianchi (2010) mentions that the main priority for nursing research is the promotion of health and well-being for all ages and social and cultural groups, followed by minimising and preventing

behaviourally and environmentally induced health problems. It can be asserted that the need to study multicultural nursing is a priority, not only for Saudi Arabia but also internationally.

Religion in relation to patient care is often addressed only as an aspect of culture and transcultural nursing. When Islam is examined as a single entity and linked with spirituality, this is often done so generically, in reference to the Muslim world in general (Wehbe-Alamah, 2008, Narayanasamy and Andrews, 2000). If the issue of Islam and healthcare is addressed in a more specific context it often reaches a wider cultural group; for example Arabs, and so is generic for the Arab world generally. In relation to the specific context of Saudi Arabia, religion and healthcare have seldom been addressed. (al-Shahri, 2002, Brown and Busman, 2003, Halligan, 2006, van Rooyen et al., 2010).

The fact that this study was conducted in Saudi Arabia means that it contributes to the pre-existing body of literature about the experience of caring for Muslim patients. This literature has explored the spiritual aspects of the Islamic faith as well as practical aspects associated with religion. However, as mentioned above, this literature, which includes practical guidelines, can be considered generic for most, if not all, Muslim cultures. The study was located in a setting where religion was an aspect of everyday life and responsible for many cultural practices of the culture. Focus on Saudi Arabia is one of the most significant contributions of the study, as it is a context well suited to revealing non-Muslim nurses' experience of care in a religiously conservative Islamic society. Indeed, the study has been shown to have a significant effect on the entire nursing experience.

Moreover, although there have been studies (van Rooyen et al., 2010, Halligan, 2006) that have explored the experience of expatriate nurses in hospitals in Saudi Arabia, these studies have focussed only on the wider cultural aspects of the experience, including religion as one aspect, or they have gone further to investigate the wider context of living and working in Saudi Arabia. This study has focused on how religion has an impact on care itself, and has looked at the issue primarily through the experiences of the nurses, but also included details of patients' experiences, revealing the experience of nursing care. Moreover, van Rooyen et al. (2010) looked at the experiences of one particular group, South African nurses who had only worked in Saudi Arabia for between three and six months. Meanwhile, the present study looks at the experiences of nurses from around the world who have between one and twenty seven years' experience working in Saudi Arabia, providing a richer insight. Halligan (2006) only focuses on female nurses, which he admits is a limitation of his study, and only studied

nurses from the ICU department, whereas the present study adds to the richness of the data by including nurses from different wards and also including male nurses.

One of the main findings of this study is that, although many of the nurses are from Western educated backgrounds and have received education and training about the importance of transcultural nursing, they showed little signs of applying the principles of transcultural nursing or even taking an interest in it. This was evidenced in two ways; firstly, when defending their professionalism they often disregarded the patients' religion as being unimportant, and secondly, they showed little effort in accommodating religious needs. It is fair to say that they did accommodate practical religious needs, such as prayer, however, this was not a consequence of cross-cultural competence training and education, it was something they had done begrudgingly and something they complained about. Moreover, in addition to religious practical needs, there was virtually no evidence that they had made a willing effort to provide for patients' spiritual needs, something that was also evidenced by the patients' opinions, and which also served to confirm other studies (Holland and Hogg, 2001, Ross, 1994, Ross, 1997) that state spirituality is an important factor to consider when providing culturally congruent care.

This study distinguishes itself from other studies conducted in the same field by addressing new areas not formerly addressed, especially in the context of Saudi Arabia. The following points indicate the contributions of this study to knowledge.

- The study did not address religious and cultural issues from one viewpoint like other studies but researched from both nurses' and patients' perspectives. This was imperative because patients and nurses were part of the same interaction, and the opinions of patients, also reveal issues about transcultural nursing in the Saudi context. Furthermore, this study used two methods of data collection: interviews and focus group discussion. These two methods inspired patients and nurses to speak out about their views honestly and frankly, as well as to listen to their peers' views. For instance, patients were unaware of competent healthcare services but were able to understand these issues. Therefore, it was important to explore them from the nurses' perspective, while receiving care from patients' perspective.
- As mentioned in the literature, the majority of studies address religion as a general issue. However, this study investigated Islamic practices in detail, since it focused on the impact of prayers and their timing, as well as on fasting during Ramadan and the impact on

nursing practice. These issues may be taken into account by Saudi hospitals in order to inform practice better.

- This study engaged with the relationship between religion and spirituality, because these two areas cannot be separated, since religion is wholly connected with faith. In order to provide holistic care to Muslim patients, it was imperative for non-Muslim nurses to understand the connection between spirituality and religion, as well as the importance of this to Muslim patients.
- This study addressed both religion and culture, although the nurses who participated in the study could not, to a large extent, distinguish between the two concepts. The results of this study emphasised the overlap between religion and culture in Saudi society. None of the studies reviewed investigated this important issue, only centring on either religion or culture. The study also explored the impact of both concepts on the provision of health care to Muslim patients by non-Muslim nurses.
- The study contributed to knowledge by focusing on nurses' professionalism in terms of caring for Muslim patients. Nurses in the study believed that Islamic religion and Saudi local culture did not affect the provision of care because they provided services according to their ethical and professional backgrounds.
- The study investigated in-depth social aspects and their impact on the provision of health care. These aspects included family members' interference in decisions related to patients and nurses', and respect by patients and family members. The study also researched the role of nurses in the hospital and their relationship with other health care providers, such as physicians, and how the two parties demonstrate their respect one another. Emotional aspects related to female patients and nurses were also studied. Female patients in the study were not able to make decisions related to their pain or diagnosis and medical procedures, and women were very dependent on their husbands or male relatives for decision making.
- Gender issues were addressed in the study, and male patients preferred to be cared for by male nurses, while female patients preferred to be cared for by female nurses. This increased the workload on female nurses because they assist both male and female patients.

### **6.3 Implications for Practice**

This thesis has highlighted deviation from Papadopoulos' model of cultural competence. Most nurses would fail if assessed against this model in terms of their journey toward achieving cultural competence. The model highlights the sequential stages required for cultural competence and notes that the nurses in the study have not met many of these requirements, such as self-awareness and empathy. Therefore, overall this indicates a lack of cultural competence. Thus, the model will be of benefit to structure and visualise where the problems exist in terms of the development of solutions.

The findings of this study have raised important issues, which should be considered in nursing practice. More specifically, these implications are relevant to non-Muslim nurses themselves, the hospital and those responsible for training and development. The following provides an overview of the implications for these parties:

### **6.4 Implications for nurses**

To avoid the problems faced by nurses in this study it is important for non-Muslim nurses to understand religion plays a significant role in the lives and care of Muslim patients in Saudi Arabia, probably more so than in other Arab Muslim countries. Moreover, nurses should understand that their concept of professionalism should be readjusted to include the provision of culturally congruent care; by discounting religion and spirituality, their professionalism in a Saudi context is limited.

The study also found that support networks for the nurses are an essential part of the nurses' adjustment into a Saudi hospital; other nurses provide valuable information about religion, culture and language, offsetting to a significant extent, the deficiencies in training and orientation. Therefore, although nurses have encountered problems, as revealed by this study, they should not give up this type of support, because it has been invaluable in all aspects of care provision to Saudi patients.

### **6.5 Implications for the hospital**

The main implications of the study for the hospital is that they need to implement equality throughout all its different structures. The study found that the nurses were not treated with respect and equality by other medical staff, the hospital administration or patients and patients' families; therefore, the hospital needs to implement policies to ensure that nurses do not suffer discrimination, while at the same time respecting the needs and wishes of patients.

It is the responsibility of the hospital to consider the needs of nurses and patients; however, this study has shown that the patients are favoured over the nurses and the nurses are treated negatively. If the hospital resolved this issue, they would then be able to fulfil their responsibility to both parties. Nurses should never feel that they are in a vulnerable position, or be exposed to false accusations, and to insure this hospital should play more of a role advocating this to nurses.

To minimise the impact that nursing in Saudi Arabia has on non-Muslim nurses personally, policies that consider and respect nurses as professionals and not just, as nurses feel, as the hired help have to be adopted by the hospital to respect the fact that they are different in terms of religion, culture and nationality. Nurses never show any disrespect towards patients and many feel that this respect should be reciprocated. The solution to these problems be a wider policy, disseminated throughout the hospital at all levels.

Translation was also found to be an issue with a significant effect on the nurses' ability to provide care, and the information provided to the patient; moreover, improper translator services wasted the nurses' time, further impacting on patient care. Moreover, the nurses should not have to depend on patients' families for translation, because this has also been shown to have a detrimental effect on patients. The hospital needs to direct more attention toward translation services as a professional service, because care very much depends on accuracy of translation. The importance of paying more attention to translation services and recognising translators as professionals was highlighted in a study by Hussein (2011).

The primary concern of the hospital was patient care, and it is important for the hospital to implement a procedure for patient visitation that will create a balance between the rights of patients to receive visitors. This is something that is of paramount importance in Saudi culture, and draws on the care needs of the patient. The aim of this should not only be to allow nurses more freedom when providing care but should also curtail the amount of influence and involvement that patients' families have over decisions about care regimens.

The ultimate results when considering and acting upon these implications is that nurses will have a more positive experience of caring for Muslim patients in Saudi Arabia, this is because it was more often treatment by all parties besides the patients and the lack of training and development that were responsible for the negative aspects of the overall experience.

## **6.6 Implications for education and training**

This study has shown that Saudi Arabia is a country that cannot be considered together with other Arab Muslim countries when training for culturally competent care. Some of the nurses in the study have had experience in other Arab countries and taught themselves about Islam, although they were equipped with the necessary knowledge and experience to provide care in Saudi Arabia, such as knowing about fasting and praying. However, because the country is religiously and culturally conservative such learning is clearly insufficient, as religion and culture have been shown to exert a very significant impact on nurses' ability to provide care. Therefore, this warrants a need for training for cultural competence that is specifically tailor-made for Saudi Arabia.

One of the main findings of the study was that poor training and orientation meant that nurses were often unprepared to work in such an environment. Waite and Calamaro (2010) state that nurses feel they are not properly prepared and lack the necessary confidence to provide culturally competent care, regardless of their educational background.

Blame should not be placed on the training and education that nurses have received in their countries of origin; indeed there is sufficient evidence in the literature review that transcultural nursing holds a prominent position in nursing education, and that the problem lies in the fact the nurses should be trained for a Saudi specific context, and that the training they receive is not conducive to the Saudi context.

Moreover, this study has revealed that many issues need to be addressed in training and education, particularly in relation to religious practical needs and spiritual needs, which have been revealed by both the patients and nurses. As for the nurses, they have revealed why it has been difficult to meet such needs, and patients have revealed where nurses have failed to meet needs. The study has shown that nurses were blind to the fact that they had to be culturally competent to be truly professional; in addition, that, in order to meet the first stage of cultural competence the nurses should be aware of themselves first.

Moreover, new areas have also been revealed based on the nurses relationships with other parties (besides patients), such as other hospital staff and patients' families. This suggests any future training and education should prepare the nurses to cope with and understand the wider organisational culture issues that they will be entering.



Non-Muslim nurses should be made aware of the procedures and culture of the hospital. This study showed that the organisational culture in the case study hospital is different to that in other countries, both in terms of attitudes towards nurses, and also operational issues such as the need to liaise with social workers and translators.

During nurses' orientation in the hospital they should be able to join a specialised language program for expatriate nurses working in Saudi Arabia, providing language skills to assist nurses to better understand patients' needs, as well as to communicate to patients the importance and benefits of care regimens.

Therefore, although some responsibility certainly lies with nursing education in the countries of origin, the recruitment agencies at the hospital itself also need to develop education and training policies, which cover orientation and the importance of the unique and diverse needs of Saudi Muslim patients, which differ from patients in other Muslim Arab countries.

The responsibility for the training and development of expatriate nurses could be bestowed on the Ministry of Health, to officially ensure that expatriate nurses are prepared to provide culturally or religiously congruent care. The Saudi Commission for Health Specialities is a department under the Ministry of Health that issues licenses and accreditation to all healthcare professionals, including nurses, as a requirement to work in the Kingdom. A recommendation would be that part of this licensing and accreditation process include an intensive transcultural training program designed specifically for caring for Muslim patients in the Saudi context.

For those who are involved in the training and development of nurses, especially those from more secular countries, this study presents interesting implications relative to the ideas put forward by Paley (2008), which state that spirituality is not important when providing care, especially in countries that are increasingly becoming secular. It may be the case that educators have to identify their perceptions of what constitutes spirituality for Western nurses personally, and what constitutes spirituality for Saudi Muslims, and bridge the gap through education and training.

## **6.7 Implications for Saudi Arabia**

Saudi Arabia is a country that employs many expatriates in numerous professions, and this study has shown that expatriate nurses are not accorded the respect they deserve in their professions. This study has also shown how this problem can arise, and who is responsible

for assisting the government in resolving this issue. Saudi Arabia is currently seeking to reduce the number of expatriates in all professions through a policy of ‘Saudisation’, and once more Saudi citizens take up nursing this may well address the issues related to spirituality. However, until that time, which could be well into the future, because of the slow uptake of nursing among Saudis due to cultural reasons, the government needs to address the problems raised in this study for the sake of the patients.

In general, this study is a critical review of non-Muslim nursing practices, relying on a phenomenological approach that gave nurses the opportunity to speak out about their views and experience of services provision to Muslim patients. The study did not rely on quantitative measurements of only specific parameters and indicators.

There is a need for the hospital and nursing education institutions in Saudi Arabia to establish academic conferences for transcultural nursing, in order to share ideas and to raise awareness of the importance of this subject to the country.

## **6.8 Limitations of the study**

It should be acknowledged that there were some limitations affecting this study. Although it was an interpretative study, it should be acknowledged that the researcher is a Muslim Saudi nursing lecturer, which means there could be a risk of bias. However, the researcher was aware of this issue throughout the interpretation of results. Moreover, the methodology was designed to reduce the impact of the researcher’s position, as shown in the reflexivity, reliability and validity 3.11 sections.

One limitation of this study related to the line of enquiry into the experiences of non-Muslim nurses. The study discussed how religion plays a role in experience, offering an in-depth investigation into how religion affects nurses and the provision of care. It was primarily concerned with patients’ religion, and while this was an objective of the study, there could have been more investigation into how the religious or spiritual beliefs or cultural backgrounds of the nurses influenced their actions. Although the nurses never revealed spoke about this issue, it should have been within the researcher’s remit to probe further. The study’s aims were to investigate from the perspective of non-Muslim nurses what it is like to care for Muslim patients, and while the study did achieve this, the religious and spiritual beliefs held by the nurses may have been relevant.

Methodologically, one of the main limitations of qualitative research methods is their reliability and validity, as well as the limited generalisability of results. Although the researcher checked the reliability and validity of the results (see the methodology chapter), they cannot be uniformly generalised to all hospitals in Saudi Arabia. The reason for this is that KFSH&RC is not representative of all Saudi hospitals, because there is a much lower turnover of expatriate nurses at the hospital because the pay and conditions are much better than at the other hospitals in the country. This information only became apparent during the study. Nonetheless, because this study used a qualitative research method, the sample was judged reasonable to answer the study questions. In the study, unstructured interviews were used to collect data, which allowed flexibility and made it possible for the researcher to follow the interests and thoughts of the participants. Furthermore, the main purpose of using phenomenology was to explore non-Muslim experiences in providing health care to Muslim patients.

## **6.9 Recommendations for future research**

Based on awareness of the limitations of this study, it is recommended that any future study include a broader sample from different hospitals, including both private and government run. This would allow a fuller investigation into the extent to which organisational culture and hospital policies impact on the experience of non-Muslim nurse's experience of caring for Muslim patients.

This study highlighted many areas where improvements to the experiences of patients and nurses can be made. There should, however, be a follow-up study into the policies and attitudes towards expatriate nurses in Saudi Arabia, to investigate shortcomings and identify their overall impact on the expatriate nurses, as well as on patient care.

For the nurses in this study there was low employee turnover in comparison to other hospitals in the country. A future study could investigate the factors behind employee turnover and the extent to which encounters with patients from a conservatively religious society play a role.

The study highlighted a major issue, which was insufficient training and development. Therefore, it is recommended to conduct research into either how the quality of training, education and orientation has an impact on nurses' ability to provide culturally congruent care in Saudi Arabia, or to assess current standards of training, education and orientation in hospitals in Saudi Arabia, with a view to improving them and subsequently patient care.

One of the limitations of the study was there was insufficient probing into the role that the nurses' religion or beliefs played in their experience of caring for Muslim patients. Therefore, it is considered valuable to carry out research specifically examining how the religion, beliefs and attitudes of non-Muslim nurses from both Western and non-Western countries have an effect on how nurses provide culturally congruent care. There could be more studies into the differences between nurses from religious countries, such as the Philippines, and nurses from more secular backgrounds, such as the United Kingdom, and how this would affect the experience of working with Muslim patients in Saudi Arabia, or between eastern and western cultures.

In this study, there was some confusion about what constituted professionalism in nursing. Future research could also focus on what constitutes professionalism for non-Muslim nurses working in Saudi Arabia, with a view to discovering the extent to which cultural competence and culturally congruent care are considered part of a nurses' professionalism.

## **6.10 Conclusion**

This study aimed to reveal the experiences of non-Muslim nurses caring for Muslim patients. More specifically the study aimed to understand, from the perspective of non-Muslim nurses, what it is like to care for Muslim patients in Saudi Arabia in terms of religion and culture, and to explore from the perspective of the Muslim patients what it is like being cared for by non-Muslim nurses, and to explore the challenges for providers of health care in Saudi Arabia in providing appropriate religiously and culturally congruent care for Muslim patients. The study adopted a Heideggerian hermeneutic phenomenology to reveal the meaning of these experiences. The premise on which this study was based was that there could be difficulties with non-Muslim nurses providing culturally congruent care to Muslim Saudi patients, especially in terms of religion, and that religion and culture had an overall impact on the nurses' experience generally.

When I began this study, I had some assumptions about the issues that would affect the experience of non-Muslim nurses in Saudi Arabia. It is known that they always experience culture shock, and that they frequently find it difficult to adjust to a strict Islamic environment and I wanted to probe deeper into this experience. In light of these assumptions, it was not surprising to find the extent of the difficulties faced by nurses and the associated causes. However, what was surprising was the lack of understanding of the spiritual needs to their Muslim patients. Spirituality was not important to them, and they were satisfied by

simply fulfilling the practical religious requirements of their patients to engage in prayer, etc. As a Muslim, I was disappointed that this was all the nurses knew about Islam or were interested in. However, the more I spoke to the nurses the more possible reasons for emerged; they felt excluded in many ways and were disrespected, often being deliberately made to feel inferior. This was no reflection on poor behaviour by the nurses themselves, they always showed a willingness to learn and to an extent fulfil practical religious needs; largely they were let down by inadequate training.

Another factor that was similar for most nurses was the fact that all of them accommodated religious practices. They understood that this was required of them, and some did so willingly, and some begrudgingly, but it was also common among all of the nurses that they showed little enthusiasm for providing culturally congruent care. It may be that they understood that they were not Muslim and could not possibly offer care with a level of understanding of these needs, or that the patients' families had such a great involvement and influence that they fulfilled the role of spiritual support. Moreover, the nurses were made to feel they were outcast both socially and religiously, and that it would not be their place to offer spiritual comfort.

Positive feedback from the patients showed that they were generally satisfied with the standard of care they received; this positive feedback should encourage the nurses. This positivity was also reflected in the personal relationships between the nurses and patients and the general mutual respect. The nurses never showed any contempt for the patients and the personal relationships were very positive and in some cases intimate. It should be remembered that not all people hold common values such as respect honesty, humility, truth, wisdom, compassion and unconditional love, which are also promoted by the five pillars of Islam (Papadopoulos and Omeri, 2008).

The study set out to examine the nurses' experiences, and it was assumed that the nurses would reveal that they had personal problems with the patients because they were of different religions and cultural backgrounds. I anticipated that the expression of their experience would be played out in the sphere of the interpersonal relationship between patient and nurse, and that differences in religion would affect that relationship. However, I discovered that most of the experiences were expressed relative to more practical aspects of nursing, which were governed by religious practices rather than spiritual ones. For example, the nurses often

spoke about Ramadan and prayers as something that had an impact on care, but never mentioned how religious differences and similarities had an impact on relationships.

Although the study revealed more feelings that are personal from the nurses, these were largely related to parties other than the patients, and their experiences were negative. However, the nurses never linked these negative experiences, e.g. not being respected, to a reduction in the standard of care that they provided. Nurses only responded that on occasion standard of care did suffer because of the practical aspects of the religion. This was supported by the study, and there was no evidence, even from the patients, to suggest otherwise.

Many factors led the nurses to feel as though they were not respected for their identities as non-Muslim, female, expatriate nurses. Their inferiority was manifest in their treatment by patients' families and the hospital, and also proceeded from the fact that the nursing profession is not as well respected in Saudi Arabia as it is in other countries. A possible reason for this was presented in this study; i.e. that the nursing profession in the country is not held in any regard for cultural reasons, and that expatriates and females may have a perceived lower status.

It was also revealed that the perception and understanding of what constitutes professionalism in nursing might be an area of confusion for the nurses in this study. In relation to this, the finding of the study report different perceptions in what constitutes culturally congruent care; both statements and actions evidenced this. However, patients, much like the nurses, thought that professional nursing care was about the practical side of administering care. However, for both parties, negative opinions surfaced when probed further on the issue of religion and culturally congruent care. Negative comments will serve to help the nurses understand that there is a need for them to improve their cultural competence.

The study also showed the majority of the nurses had similar experiences. In relation to issues related to religion and culture, they all provided similar examples and discussed the same issues, such as patient's families, fasting in Ramadan and prayer having a negative impact on care from their perspective.

In relation to literature specifically about transcultural nursing in Saudi Arabia, this study agreed with the main points made, including findings, such as Islam having an impact on workload. However, more in depth and intricate issues have also been confirmed by this study. Fedorowicz and Walczyk (2006) comment that although Arab Muslims have every

confidence in Western medical practices, as evidenced in the present study, they may also depend on holistic spiritual care, as was confirmed in the present work. Another example is that the influence that is exerted by patients' families, which is to such an extent that they almost control the whole care process, found this elsewhere in the literature, something else that was found in my study.

Overall this study has highlighted a need to focus on providing culturally congruent nursing care in Saudi Arabia; firstly, because this issue has not been addressed properly in education and training, and secondly, because Saudi Arabia is a country that has distinctive and specific needs in relation to cultural competence. This study shows that the problems that adversely affected nurses' experience were mostly attributable to insufficient education and training to work in the Saudi context, or at the very least lack of preparation to work with Saudi patients and poor employment policy practices at the hospital itself.

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## **Appendix 1: Ethical Approval**

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## Appendix 2: Consent form for the participants of the study

**Research title:** A Phenomenological Study of Non-Muslim Nurses Experiences of Caring for Muslim Patients in Saudi Arabia

**Researcher:** Dalyal alosaimi

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E-mail: Dalossumy@yahoo.com

Mobile number 0555521206

❖ Hospital number:

Patient Identification number for this project:

❖ Consent form (Patient)

**Title of project:** Phenomenological Study of Non-Muslim Nurses Experiences of Caring for Muslim Patients in Saudi Arabia

Name of Researcher: Dalyal al-osaimi

- ❖ I confirm that I have read and understand the information sheet dated for the above study and have had the opportunity to ask questions. ☐
- ❖ I understand that my participation is voluntary and that i am free to withdraw at any time, without giving any reason, without my legal rights being affected. ☐
- ❖ I understand that section of my research record where appropriate may be looked at by responsible individuals from the Ethics committee or from regulatory authorities where it is relevant to my taking part in research, I give permission for these individuals to have access to my records.- ☐
- ❖ I agree to take part in the above study.- ☐

Name if participant: Date: Signature:
.....
(If different from researcher) Date Signature
.....
Researcher: Date Signature
.....

## Appendix 3: Interview Schedule Guide

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Because this study adopts a semi-structured approach to interviewing in the interviews and focus groups it was decided to use an interview guide instead of a list of questions. This allows the researcher to explore experiences while at the same time keeping the interview within the aims and objectives of the study.

### Nurses

- Evidence of transcultural nursing education in academic studies
- Evidence of transcultural nursing education in practical training
- Feelings, opinions and insights of the experience of caring for Muslim patients
  - Tell me about your experience of caring for Muslim patients?
  - Is there a difference between caring for non-Muslim patients and Muslim patients?
- Religion as a factor in the experience
  - How does religion affect the care?
  - How does the religion (Islam) affect you as a nurse?
  - Is it easy for you to provide culturally sensitive nursing care?
- Culture as a factor in the experience of caring for Muslim patients
- Communication as a factor
  - Are there communication barriers?
  - Do these barriers impact on your experience?

### Patients

- Opinions and feelings about being cared for by non-Muslim nurses
- The importance of religion in the care relationship
- The extent to which religious practical and spiritual needs are met
- Language issues

## **Appendix 4: Information Sheet in English (nurse)**

**Research title:** A Phenomenological Study of Non-Muslim Nurses Experiences of Caring for Muslim Patients in Saudi Arabia

**Researcher:** Dalyal alosaimi

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### **Study title**

Phenomenological Study of Non-Muslim Nurses Experiences of Caring for Muslim Patients in Saudi Arabia

### **The study**

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Take time to consider whether or not you wish to take part. Please contact me to ask about anything that is not clear or if you would like more information.

Thank you for reading this information sheet.

### **What is the purpose of the study?**

The aim of this study is to collect information from female non Muslim nurses about their experiences of care -Muslim patient. This information will be used to help the nurses to meet and improve the care needs of Muslim patients

### **Why have I been chosen?**

You are being invited to take part in this research because you fit the criteria of the study. You are one of 10 nurses who are being asked to share your experiences of providing care. I hope to learn from listening to your experiences which are key to my study.

### **Do I have to take part?**

No, the study is entirely voluntary. Whether you choose to take part or not, this will not affect your work in any way. If you decide to take part, you will be given this information sheet to keep and you will be asked to sign consent from. if you decide to take part, you are

still free to withdraw from at any time. You do not need to give a reason if you wish to withdraw.

### **What is involved?**

If you are willing, we will invite you to participate in either an interview or a focus group (your choice) aimed at exploring your education experience on the care of Muslim patient .we think the interview will last about 45 minutes. The focus group will not include more than 5 nurses and will take no longer than 1 ½ hours. We will. With your permission tape-record the interview/focus group and will ensure you cannot be identified on the transcripts.We could interview you at your home, in the hospital or at another venue of your choice.

### **What happen to the information?**

All the information from the interviews will be confidential.dat gathered from the focus group will be anonymised.the reports of the research will be anonymised and kept confidential to the research team. No one will be able to identify you from the study .the data from the interviews/focus group will be put into a computer, which is password protected ,to be analysed .at the end of the project all the transcripts will be shredded. The tapes from interviews are transcribed( listened to and written down in full).The notes taken by researchers, the tapes and the transcripts will be kept safely in locked offices at the university and only the research team can see it. Notes, tapes and transcripts will only have codes and not names in order to safeguard confidentiality .At the interview /focus group transcripts will have any features that could be used to identify an individual removed. All data will be treated in accordance with the current Data Protection Act.

### **What if something goes wrong?**

In the event that something does go wrong and you are harmed during the research study there are no special compensation arrangements. If you are harmed and this is due to someone's, negligence then you may have ground for a legal action for compensation against De Montfort University, but you may have to pay legal costs.

### **What if I wish to complain?**

Please raise any difficulties or questions with Dr Sue Dyson; Head of Research for N&M and research co-ordinator on **(0116) 201 3881** email [smccartney@dmu.ac.uk](mailto:smccartney@dmu.ac.uk) **If you have any complaints please contact -----**

**What will happen to the results of the study?**

The results will be made available following the completion of the study in 2013. We will provide a summary and you will be able to receive a copy of this if you wish

**Who is organising and funding the study?**

The study is organised by researchers at De Montfort University. The study is being funded by the Healthcare Workforce Deanery (HWD). The study has been approved by the Ethics Committee of De Montfort University.

**Contact for further information** If you would like any further information about the study please contact Dr Sue Dyson (0116) 201 3881. Thank you for taking the time to read this information sheet. We are very grateful for your participation in this study. Dr. Sue Dyson, Faculty of Health and Life Sciences, School of Nursing and Midwifery De Montfort University, Leicester. (0116) 201 3881 [smccartney@dmu.ac.uk](mailto:smccartney@dmu.ac.uk)

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## Appendix 5: Information Sheet in Arabic (patient)

ما عنوان الدراسة لخبره الممرضات الغير مسلمات لرعاية المريض المسلم ؟

المشارك عزيزتي/عزيزي المشاركة

أنت مدعو للمشاركة في هذه الدراسة و لكن قبل أن تقرري من الضروري أن تطلعي على أهدافه الدراسة . أرجو إن تقرئي هذه المعلومات  
بتمعن و بإمكانك أن تناقشها مع من تريدين . في حال وجود أي غموض بإمكانك استفسار في الباحثة. خذي الوقت الكافي لتقرري  
المشاركة أو عدم المشاركة

ما هو هدف الدراسة ؟

في De Montfort أنتي مدعوة للمشاركة في بحث تقوم به ( دليل العصيمي) طالبة الدكتوراه في كلية الصحة و العلوم الحياتية في جامعه  
بريطانيا . تهدف هذا الدراسة التعمق في دراسة الثقافات المختلفة لتقديم الاقتراحات لتحسين الخدمات التمريض في المملكة العربية  
السعودية .

لماذا وجهت لي دعوة المرضى؟

أنتي مدعوة لأنك أحدى المرضى المسلمات اللواتي يحصلن على الرعاية الصحية في المستشفى الملك فيصل التخصصي و مركز الأبحاث  
.

هل يجب أنشارك ؟

قرار المشاركة يعتمد عليك , إذا أردت المشاركة سوف تعطين هذه المعلومات للاحتفاظ بها و يطلب منك التوقيع على قرار الموافقة.  
بإمكانك أيضا الانسحاب من الدراسة في أي وقت دون إعطاء إي مبرر, قرار الانسحاب لن يؤثر على نوعية العناية المقدمة لك .

ماذا سوف يحصل لي إذا قررت المشاركة ؟

لنستطيع تكوين فكرة مكتملة عن المريض المسلم و تلقيه الرعاية التمريضية من قبل الممرضة الغير مسلمة و سوف تسجل صوتياً حسب  
ما تفضله المشاركة ستكون المقالي في المستشفى أو بعد خروجك و تحديد موعد المقابلة .

ما هي الفائدة الشخصية من المشاركة ؟

ممکن أن الفائدة لن تكون شخصية بالنسبة لكي، و لكن بمشاركتك بالبحث سوف تساعد في تحسين الخدمات التمرضية المقدمة للمريض المسلم من قبل الممرضة الأجنبية الغير مسلمة .

### ماذا يجب أن أعمل لأشارك في هذا البحث ؟

إذا كان عندك رغبة بمشاركته الرجاء الاتصال بلباحته دليل العصيمي هاتف رقم : 0555521206

و من صم سوف تقوم الباحثة بالاتصال بك للإجابة على إي استفسار أو لترتيب [dalossumy@yahoo.com](mailto:dalossumy@yahoo.com) أو البريد الإلكتروني موعد المقابل

## اقرار الموافقة

### خبره الممرضات الغير مسلمات لرعاية المريض المسلم

☐

-اقر انني قرأت واستوعبت ورقة المعلومات المتعلقة بهذه الدراسة وكان لي

الفرصة في طرح الاسئلة التي اريد.

☐

-افهم ان مشاركتي تطوعية ولي الخيار بالانسحاب في اي وقت من غير اعطاء اي مبرر.

☐

-اوافق علي المشاركة في البحث .

نعم لا

☐☐

ارافق علي تسجيل المشاركة صوتيا.

☐☐

ارافق علي استعمال اي اسم مستعار في حالة نشر البحث

اسم الباحثة التوقيع

اسم المشاركة التوقيع



## Consent form

### Non-Muslim Nurses

Statement	Yes	No
1. I confirm that I have read and understood the information sheet of the study related to non-Muslim nurses' experience in providing health care to Muslim patients. I have also the opportunity to ask questions and enquire about different things related to the study.	<input type="checkbox"/>	<input type="checkbox"/>
2. I understand that my participation in the study was totally voluntarily and was free to withdraw any time from the study.	<input type="checkbox"/>	<input type="checkbox"/>
3. I agree to take part in the study	<input type="checkbox"/>	<input type="checkbox"/>
4. I agree to record my the interview	<input type="checkbox"/>	<input type="checkbox"/>
5. I agree to take part in the study	<input type="checkbox"/>	<input type="checkbox"/>
231 <sup>6</sup> . I agree to use a nickname in case of publication	<input type="checkbox"/>	<input type="checkbox"/>

